the Canadian Nurse

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MONTREAL
AUGUST 1961

HIGHLIGHTS

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THE CANADIAN NURSES' ASSOCIATION

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INDEX TO ADVERTISERS

AUGUST, 1961

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AUGUST 1961

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Between Ourselves

Prince Edward Island, situated in the Gulf of St. Lawrence, is a tiny dot on the map of Canada. Its greatest length, from east to west, is about 145 miles; its breadth varies from 4 to 34 miles. The island is supposed to have been discovered by Cabot in 1497. It so charmed Jacques Cartier on his visit that he is said to have called it "the Garden of the Gulf."

This tiny province, with a total population of less than 100,000 has been experiencing, in miniature, all of the problems associated with the shortage of nurses that are familiar elsewhere in Canada. The eight general hospitals that serve the people in various areas, are supplemented by two mental hospitals and a tuberculosis sanatorium. Despite the annual graduations from the schools of nursing, the numbers of graduates available for staff work has remained fairly constant for many years since, as elsewhere, nurses are constantly on the move to other provinces or countries. To meet the pressing need for more pairs of hands, the Association of Nurses of Prince Edward Island, in cooperation with the provincial government, embarked on a training program for nursing assistants. Miss IDA MARGARET MACKAY, president of the Association, describes the developments in her guest editorial.

* * *

The past 25 years has seen the expansion of a broad new program for the prevention of many disabling conditions and, even more important, for greater understanding of the needs of those who are physically handicapped. Previously, rehabilitation programs had focussed principally on injured workmen, disabled war veterans, the blind, and patients with arrested tuberculosis. Today, emphasis is being placed on the development of services for all handicapped persons, regardless of their disability. The more recent additions to the growing list requiring some rehabilitative assistance include: Alcoholics, mentally retarded and cerebral palsied children, cardiac and arthritic patients. Even old age as a disabling factor is now receiving attention.

Rehabilitation programs have been sponsored by both voluntary and public organizations. In many of the large cities, the necessary facilities are provided by regular departments in general hospitals, special clinics for particular disabilities, separate rehabilitation centres, sheltered workshops and special classes or schools for the education of handicapped children.

We are all more or less familiar with the broad outlines of the programs of rehabilitation. Less well known is the role that is being played by the National Employment Services. The main responsibility for counselling vocational assessment and job placement of persons with occupational handicaps is carried by a large corps of specially trained placement officers located in the larger offices across the land. Any person in need of this assistance may use it. The accumulated records provide many human interest, success stories attesting to the renewed sense of personal worth.

Where does the average nurse fit into this picture? First, she needs to understand something of the emotional crisis that overwhelms a disabled person when the full meaning of a handicap dawns. Dr. Jousse discusses that phase of the problem. Second, the nurse should be aware of her role in assisting the patients to meet this crisis. Miss MacGregor points out the urgent need for the nurse to realize that every part of the care given must be viewed as an aspect of the total rehabilitation program. Third, the nurse should know what the broader phases of rehabilitation include and who is responsible for them. Dr. Gingras supplies many of the answers. Finally, the nurse should realize the importance of restoring the dignity of economic independence to her patient. Miss Sénécal points the way here.

* * *

Sisters Mance Décary and Jeanne Forest of Montreal were highly amused by the curious glances they received at the Congress in Melbourne. Since there is no branch of the Grey Nuns in Australia, their habit was completely unfamiliar. One lay nurse summoned up enough courage to ask "Are you Jewish nuns?"

A human being, as much as he needs bread, needs education throughout his existence and every human being has the right to it. — CHARLES H. BARBIER

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Description—Tablets contain either 2.5 mg. or 5 mg. of methyclothiazide, an oral diuretic of high potency, long duration of action and low toxicity.

Precautions—If a high dosage is continued beyond three consecutive days, particular attention should be given to the patient's electrolytic status. Supplemental citrus fruit juices or potassium may be required.

Dosage—Usual adult dosage is 2.5 to 10 mg. once daily.

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Random Comments

Dear Editor:

Reference to the "time consuming" business of Canada's largest Registered Nurses' Association (April "Between Ourselves") comes to us at an opportune time, just when Ontario's large Educational Conference was closing and our annual get-together is soon to begin. One wonders if at the close of our deliberations it will be said of us what was written of the Ontario Education Association namely, "they had *vital matters* to consider" but while considering them members where "stunned by a barrage of old ideas masquerading as something new."

May I suggest there is nothing new under the sun and something very old in the March-April *R.N.A.O. Bulletin's* report that "proposed legislation for a College of Nurses" (that was endorsed unanimously by all Ontario members) "will be left in abeyance for this year."

One of the world's outstanding women and nurse educators informed the Ontario Government that "hospitals establish training schools for nurses not primarily to train nurses but to get their work done." The direct problem, she said, was (and still is) "how to place training schools on a sound financial basis so that there can be real freedom to develop the training of nurses on its merits as an *educational experience*, in which the hospital plays a part but which it *never controls*."

These remarks were made by Miss Adelaide Nutting approximately 50 years ago. Some of the "time consuming of Canada's largest Registered Nurses' Association" could be just a barrage of old ideas masquerading as something new and could also be the reason why many members have grown weary of and impatient with the endless conferences, pilot projects and surveys that appear to accomplish nothing but lead to questions such as "What is the matter with us?" or "What is expected of a professional nurse, and who decides what is quality nursing care?"

In my book of knowledge "quality nursing care" is the service rendered by women who are educated in and trained to recognize fundamental human needs. This makes her capable of supplying skilled help in the restoration of health and the prevention of disease, and, may I add, of providing intelligent care for the dying.

I was pleased to note, also in the April issue, Mr. Donahoe's address wherein he states "The nursing profession is justly exercised about the maintenance of a high quality of care for patients." I presume he means in cooperation with hospital insurance.

"We (the Nova Scotia Hospital Insurance Commission) have encouraged the employment of qualified personnel," he states. Would that all provincial commissions had done likewise — it is the only way we can avert tragedies such as occurred in Regina. Mr. Donahoe's concluding remarks were most interesting; "As long as the nursing profession maintains its standards and is actuated by the ideal of service, . . . the sick and the incapacitated will be the ultimate beneficiaries of the joint efforts of those responsible for a Hospital Insurance Plan and for nursing services."

Ontario readers please note. He does not suggest that the Hospital Services Commission *take over* or *sponsor* the training of nurses, not even as a "Pilot Project." The emphases are mine.

MARTHA GIBSON, Ontario

Dear Editor:

It is now over a year since I had the pleasure of visiting you in your office in Montreal. What a long time ago that seems; now I can hardly believe I was ever there.

Whilst with you I took a two-year subscription to your *Journal,* which I have certainly not regretted — I find it most valuable and interesting.

My best wishes to you and to the continued success of your *Journal* — French and English, of course. I am looking forward to many more stimulating articles.

JOAN EVETT, Gloucester, England.

Dear Editor:

Congratulations on the May, 1961 issue of *The Canadian Nurse!* The articles by Rae Chittick and Elizabeth Logan provide stimulus for thought as we seek to clarify the true essence of nursing.

THELMA POTTER, Nova Scotia.

Dear Editor:

Could you please tell me where I could purchase a name pin for my nurse's uniform? It would be the ivory-colored pin with black letters that I am interested in.

Mrs. IAN CAMPBELL, Yukon.

¶*There are many places where such pins can be secured. One address is Dismas Society and Shop. P.O. Box 74, Snowdon*

Sta., Montreal, Que. They will mail the pins to any address in Canada. The price is 65 cents each pin. Ed.

Dear Editor:

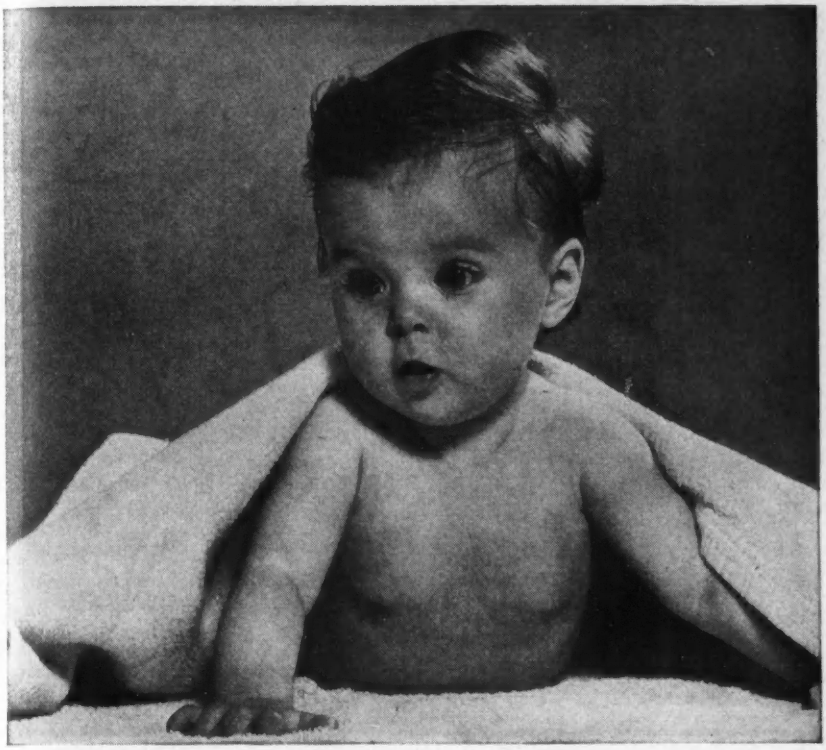
As I was reading through my copy of the March, 1961 issue of *The Canadian Nurse*, I noticed, in "Random Comments," a request for a second copy of the November, 1960 issue; then I recalled that I had not received my copy that month. Would there by any chance of getting one now, please? I am very interested in receiving it, as it would be a pity to have a copy missing after 10½ years of keeping every one of them. I noticed that this particular issue contained a series of articles on nutrition, and that is another very important reason for asking you to send another copy, if it is at all possible.

May I also tell you how much I have enjoyed reading *The Canadian Nurse*, although I have been away from active nursing for more than nine years, and have a large family to look after. It has been a pleasure to keep up with anything concerned with our profession through this magazine. It is also a means of contact with your country in which I stayed for more than three years during my training at the Ottawa Civic Hospital.

I shall duly renew my subscription in October of this year, and please let me know if I owe you for the copy I have requested. It probably was not your fault as I have been getting all the copies very promptly since 1950.

I hope I have not bothered you too much. Please forgive me if my English is not too fluent or as correct as it should be.

MARGRET BEICK DE SCHWEDHELM, Mexico.



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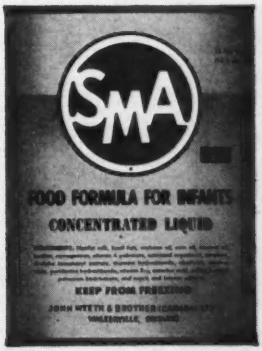

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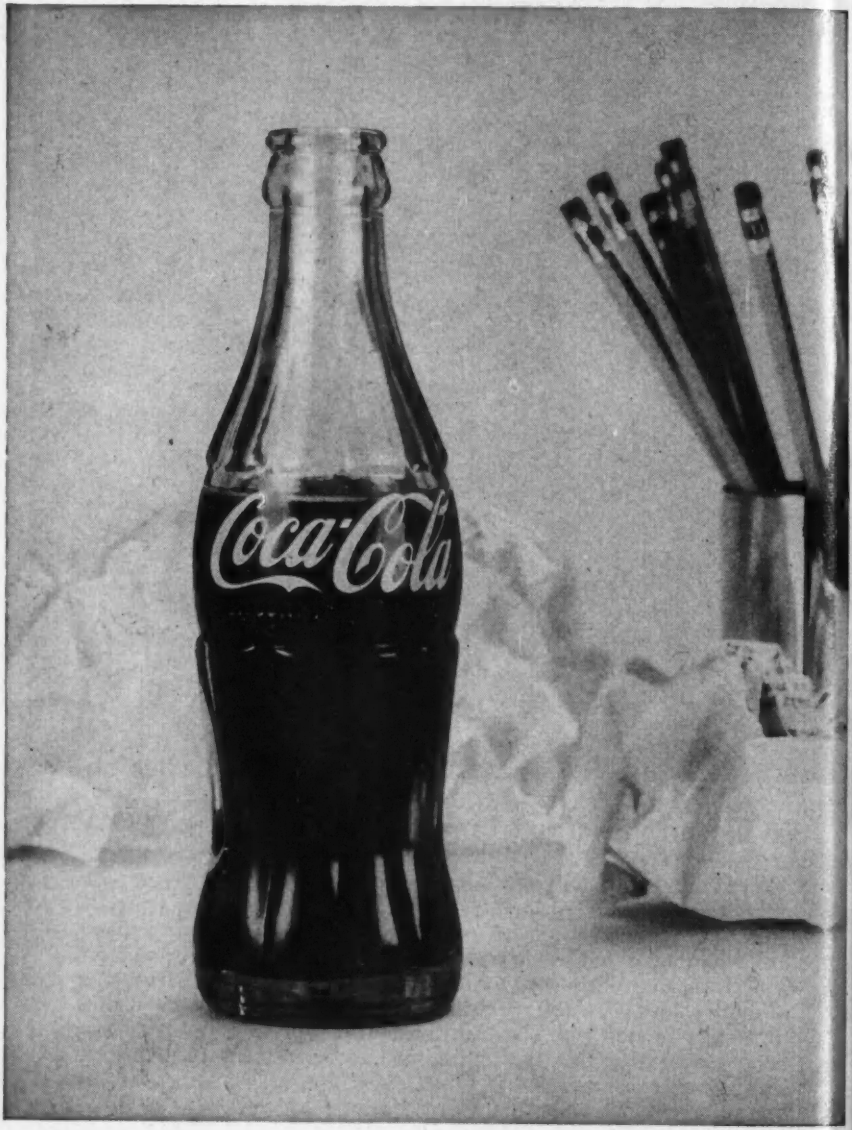

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THE CANADIAN NURSE

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VOLUME 57 NUMBER 8

MONTREAL, AUGUST 1961

CONSERVING NURSE POWER

THE TURN OF events during and after the Second World War brought into sharp focus the need to tap another source of supply to provide health workers to meet the nursing needs of our people. Through the efforts of the Association of Nurses of Prince Edward Island, "an Act to Provide for the Training, Licensing and Practice of Nursing Auxiliary Personnel," was assented to in the Legislature in April, 1952. The short title of this Act is "The Licensed Nursing Assistants' Act."

The next logical step was the organization of a nursing education program to prepare this category of nursing personnel to function in our hospitals and health agencies. The general hospitals expressed little interest in adding such educational programs to their responsibilities; the patients were cared for almost exclusively by nurses and students of nursing. Generally speaking there was a lack of awareness of the contribution that nursing assistants could make in a hospital situation, though, for a number of years the provincial hospitals had been conducting one and two year training programs for attendant nurses in tuberculosis and psychiatric nursing.

Nurse educators, looking to the conservation of teaching facilities and personnel, were interested in seeing a Central School for Nursing Assistants established. With this objective in view, representatives of the Associa-

IDA MACKAY

tion of Nurses approached the provincial government and requested that the feasibility of financing such a school be investigated.

In the years 1957-59 when a "Citizens' Committee on Hospital Insurance" was studying our health needs as they related to a proposed program of hospital insurance, the province obtained the "Consulting Service in Hospital Planning, Organization and Management" of the firm of Agnew, Peckhan and Associates, Toronto, for the purpose of conducting a study of hospital requirements for Prince Edward Island. In the 234-page report of this study, published in September 1958, the following recommendations appear in relation to nursing needs:

1. That the training of nursing assistants be undertaken on a large scale.
2. That a Central School be set up in preference to individual hospital courses, with academic work based at one centre, possibly Riverside Hospital, with practical work at selected hospitals.
3. That the Committee administering the Nursing Assistants' Act together with the Association of Nurses should clarify the terminology referring to nursing personnel other than registered nurses.
4. That a joint hospital and secondary school program could be considered.

Early in 1959, the Executive Committee, first appointed in 1952 under the Nursing Assistants' Act, was reactivated and the processes of implementation of the Act began. Within a year the plan for a Central School materialized. The school was opened in April, 1960.

The financial support of the training program is provided by the provincial government hospitals and by the general hospitals as a shared cost under the provincial hospital insurance plan. Any hospital in the province may sponsor a pupil nursing assistant. In turn, the pupil signs a contract with this hospital to work there for one year on the completion of her training program. She would, of course, be paid as a licensed nursing assistant during the latter period. This was done advisedly as one means of stabilizing nursing service.

The training program is one year in length, the first three months of which are spent at the Central School in a pre-clinical program of basic nursing. The next eight months are spent at two affiliate hospitals where the pupil obtains clinical experience in the medical, surgical, pediatric, obstetric, psychiatric and geriatric areas of nursing. The last month is spent at the Central School for some additional classes, for review and for writing achievement tests.

For the purpose of orienting the allied profession to the functions of the nursing assistant, clearly defined responsibilities of the licensed nursing assistant are circulated to the hospitals. The Association of Nurses has worked through committees to set the tone for acceptance of this new person in the hospital family.

The future holds the complete answer to the provision of good nursing care for our people, but we feel that we have taken a big step in using our provincial resources to attain this goal. We are happy to report on the splendid cooperation of the provincial government, the hospitals, both private and governmental, as well as the health organizations, in blending their efforts to establish a training program for nursing assistants.

IDA MACKAY,
President, Association of Nurses of Prince Edward Island.

Emotional Aspects of Physical Handicap

A. T. Jousse, M.D.

Rehabilitation means doing what needs to be done to get a person going.

Rehabilitation of the sick and the physically disabled is simple of concept but difficult of execution. Perhaps this is so because we see, and are impressed by, the obvious physical defect but oftentimes fail to recognize that bodily function, in both the fit and the unfit, is not determined so much by anatomical perfection or physical prowess as by the purpose of the mind and the drive of the emotions operative within the body. Perhaps, too, we fail to understand the meaning and significance of rehabilitation. It has become obscured by the somewhat abstruse definitions which have been evolved by various workers in the field. The common definition: "Rehabilitation means the maximum restoration of the patient in the physical, emotional, intellectual, social and vocational areas," is obviously an attempt to cover every conceivable situation. A sounder definition is: Rehabilitation means doing what needs to be done to get a person going following illness or injury.

The problems of the disabled have been viewed from many points of view — from that of the physician, the surgeon and nurse, who sometimes place most emphasis on the care of persons who are acutely ill and who tend to lose interest during the chronic phase; the patient who must live with a disability and seeks help from those best able to render it, first, the doctors and nurses, and if they fail, non-professional people of good will; of the patient's family who may be caught in the midst of social and economic disaster as a result of the disability; of the insurance company who must pay indemnity as long as incapacity lasts; of the sociologist who views the problems of society in perspective, judiciously and coldly, without emotional entanglement. It is therefore not surprising that a variety of opinions exist.

Dr. Jousse is director of physical medicine, University of Toronto.

Then and Now

The need for rehabilitation derives from social and economic factors as well as medical ones. Fifty years ago, acute and often fatal epidemic disease occupied the attention and energies of the members of the medical profession and their allies in the nursing profession. The efforts of all were directed toward the goal of saving lives. Because death at all ages was so commonplace, those who survived, even though disabled, were thankful for this blessing. Many who were unable to work productively again, were able to find a niche into which they might nestle. Perhaps it was in a rural community where there was a surplus of food and accommodation, and little else was required of life.

In such a society it was respectable for the disabled to be non-productive and dependent. Many handicapped older folks, and some younger ones, were content to affix themselves to a productive member of a family, farmer or business man. They shared his hearth and table without fear of disfavor from the community. Today our houses, our needs and, indeed, our means no longer permit this sort of arrangement.

On the other hand, our society provides opportunities for useful living hitherto not available. Indeed, 50 years ago there was little cause for criticism if the amputee, the arthritic, the deaf or the blind did not return to gainful employment. The remunerative work whether it was in the factory or on the farm, required a much more rugged frame that it does today. Automation had not developed to the stage where the weak and the frail could produce in an economically worthwhile fashion. Following a plough required

greater physical fitness than operating a modern combine. Stocking a coal-burning locomotive with a shovel was physically demanding to a degree not equalled by the operation of a diesel locomotive.

Moreover, certain personality disorders were less disrupting in that setting than they are today. A paranoidal schizophrenic might be able to follow a plough or a trapline although he is quite unable to work in association with others on a modern production line, or unfit to withstand the strain of operating a city bus or a diesel locomotive.

The need for rehabilitation existed then just as much as it does now. In the same way, the need for the treatment and control of tuberculosis, malaria, syphilis and poliomyelitis has existed since the dawn of history. Until recently, however, satisfactory measures for the prevention and treatment of these disorders were lacking. Treatment was largely ineffectual. In much the same way, the successful development of rehabilitation measures awaited changes in the social and industrial fields. These conditions have been met in the form of a well-organized social pattern with social welfare measures spelled out by law and a degree of automation that places less of a premium on physical strength and endurance.

In addition, the demands of society 50 years ago were less stringent. The standard of medical care was lower, just as the standards in the field of transportation were not as high. A horse and buggy or a Model "T" sufficed. Today, neither of these methods of locomotion would be acceptable. It is equally unacceptable to rely solely on anti-diphtheria serum for the protection of our children. We demand the use of toxoid so that the condition may not occur at all. So it is with the sequelae of trauma. Fifty years ago a Pott's fracture of the ankle frequently resulted in persisting pain and incapacity. A working man who suffered this injury often endured permanent functional impairment. Now, we expect persons who have experienced even severe compound fractures to be restored to a high functional level. Failure to attain this level is, many times, a cause for dissatisfaction with treatment. Indeed, this dissatisfaction may be reflected in court action leading to monetary award for persisting disability. Such disability would have been considered as an inevitable consequence of disease or injury only a few years ago.

Our outlook has changed with our increased knowledge and understanding of disease and disability. As we have grown more competent to prevent and treat disease and to minimize the residual deficits, we have also grown more demanding of the victims. We exert greater pressure on them, socially and professionally, to perform successfully in the physical, social and vocational fields than was formerly the case. It was easier to be disabled 50 years ago.

Curiously enough, we seem to have lowered our standards of performance in other areas. We seek constantly to find an excuse in the intellectual and emotional areas that have to do with personal behavior for our failures to achieve. Alcoholism is now classed as a disease over which the victim is said to have no control. This has become an acceptable excuse for all sorts of unacceptable behavior, such as: Non-support of wife and children; irresponsible driving of a motor car; even, on occasion, for bank robbery and manslaughter. Yet if these same individuals contract poliomyelitis and become paralyzed, in due course they are expected to become personally independent, socially integrated and gainfully employed, even if they never worked steadily before becoming physically disabled!

Criminal behavior is likewise attributed, perhaps rightly, to environmental and hereditary factors beyond the individual's control and for which he cannot be held responsible. Once more if, in criminal pursuit, he happens to have his spinal cord transected by a policeman's bullet, he then becomes part of a rehabilitation program. Much to his surprise, more people become interested in him than he believed even knew of his existence. Whether he desires it or not, he is processed, assessed, evaluated, exercised, educated and placed in employment.

Some Things Remain Unchanged

However different our society may

be in structure and function from that of 50 or more years ago, the individuals who comprise the units of it still react to fear and pain in the same fashion as human beings have responded since the dawn of history. With the great emphasis on achievement and material success, particularly for the male; with material success being the key to personal freedom and self-respect; with the achievement of these goals being the chief sources of satisfaction available to many, it follows that the restoration of the physically disabled is measured in terms of social and economic achievement. To fall short of these goals is to be a failure in a highly competitive society.

The emotional forces aroused, the fear engendered and the pain caused by physical disability vary in accordance with the age of onset; the type of person suffering the hurt; the severity of the injury and the extent to which it affects performance and appearance. To assist such persons we must recognize these factors.

Let us consider first the age of onset. For the child who is born with a disability which affects his performance, realization that he is different, that he is handicapped and unable to compete successfully must dawn slowly as he matures physically and socially, emotionally and intellectually. In the preschool period, an only child on an isolated farm would not realize the extent of his handicap. Protected, aided and abetted by his parents he could carry on quite happily if he enjoyed their affection and support. The emotions engendered in the parents by the realization that they had a disabled child would, of course, influence him somewhat. The parental attitude might be one of over-protection, rejection or acceptance of the child as he is. In every way possible this last attitude must be fostered. Lacking brothers and sisters with whom he could compare himself, the child would not be fully aware of his impairment until he reached school age. When this time arrives he is forced into contact and competition with other individuals of his own age. This often brings the first realization of being different and at a disadvantage.

The youngster's reaction may be one of hostility, withdrawal and introversion or over-compensation. The basic feelings behind these reactions are fear and loneliness, hate and anger, each in turn being uppermost. The dominant emotion is determined by the type of personality of the patient and the conditioning received from the early environment.

Critical Periods

There are other equally critical periods in the life of the child born with a severe physical defect. As maturity approaches, the teenage child with a significant disability is often incapable of relating appropriately to the opposite sex. This introduces stresses, strains and anxieties that may impair intellectual and physical performance to an extent greater than that occasioned solely by the handicap. As the patient's performance lags for any reason, his self-confidence, which may have been deficient initially, is determined further. He feels that he is isolated from his fellows. Later still, the isolation is confirmed when the disabled young person sees his peers launch forth into the field of employment and homemaking which appear to be beyond his ken. He settles down to a period of existence that provides little reward for little accomplishment. If the disability is so severe as to render him completely dependent, he is haunted by the dread of the day when his parents will no longer be able to look after him and he will be forced to rely on the impersonal services rendered by an institutional staff.

It may be argued that the child born with a serious disability and who, therefore, has never known complete health, is less to be pitied than he who, having enjoyed good health, sees it taken from him. There is no final answer to this argument as there is no final answer to the statement that "It is better to have loved and lost than never to have loved at all." The young child or adult who has enjoyed good health and is suddenly deprived of it, is forced into realization of the calamity that has befallen him with great abruptness. He may be subject to extreme reactions of fear, hostility and depression. However, it may be supposed that, having enjoyed a developmental period under normal physical

circumstances, he is in a stronger position to cope with the disaster that has befallen him.

Serious physical disability acquired during the adolescent preparatory phase of life when the young person is acquiring an education, results in the sudden creation of a great gulf between him and the achievement of accepted goals in life whether these are in the field of athletics, of social success or in a vocation. Such an individual is faced with the very difficult task of relinquishing his goals and ambitions since they may no longer be realizable. The bitterness and frustration that may result is easy to appreciate. The despondency of such a person is a natural outcome of the circumstances. It is easy to understand how cynicism and hostility toward the world may develop. At such a time there is need for much guidance and counselling that will help the individual to re-align his thinking so that new goals may be established. These goals must be realistic in relation to his new physical status. They must be attainable and satisfying to him. Those who would assist at this time must understand not only the plight of the patient, but as well, should know that the enforced dependence is a bitter pill that may overwhelm him with a sense of guilt and shame.

We may argue that it is easier to face physical handicap when the training for life is completed and one is established in vocation. This may be true *if* the education is such as to permit ready adaptation from an active vocation to a sedentary one. Too often, however, a new start is required and there may be little enthusiasm for the endeavor. Such an adjustment may be called for at a time when responsibilities for a spouse and children have been assumed. Quite often disability under such circumstances brings with it a feeling of failure, a threat to loved ones, an economic menace that is usually lacking in the younger formative years. For a person disabled at or past middle age, comes the realization that it may be too late to create a new life. Hence the sentence can become one of enforced early retirement with little opportunity for the development of fresh interests and avocations.

Reactions to Disability

Irrespective of the age of onset, the attitude and the emotional reaction to the restraint imposed by physical disability is determined to a great extent by the type of person who is involved. It has long been common knowledge that people differ in their reaction to success or failure, to the major crises of life including illness, disability and death. Some men are good soldiers but are poor peace-time citizens. Some worthwhile peace-time citizens are poor soldiers. We variously attribute these differences to heredity or environment without understanding the role played by each. The view of the average man that good qualities are born in some men and women, is a sound view. It is not easily shaken by the somewhat extreme emphasis sometimes placed on environmental factors. The distinguishing characteristics of fortitude are often present in childhood. Though these may change in form with developing maturity, the inner strength persists.

Difficult as it may be to measure fortitude, some very interesting studies along this line have been conducted. A group of psychiatrists who recognized that certain individuals tend to minimize painful and annoying stimuli while others over-respond, conducted the following study:

> The subjects were blindfolded and given a rectangular block of wood to handle and manipulate. Suppose that the block of wood was five inches long. The subject was required to indicate the supposed length of wood on a ruler or similar object while still blindfolded. Certain individuals invariably overestimated the length of the block. Others just as regularly estimated at less than the correct length.
>
> It was found that the individuals who *overestimate* the length of the block are the same ones who *overreact to painful stimuli* (overreactors or exaggerators) and the ones who *underestimate* the length are the ones who *tolerate pain* with little outward reaction (diminishers). However, all the advantage is not on the side of the diminishers. It was found that this group endure restraint less well — restraint such as that imposed by confinement in a prison or in a bed through illness and injury. Those who overestimated the length of the

block of wood withstand confinement much better. Perhaps we have seen evidence of this in the big, rough and tough person who becomes a dreadful patient when faced with the restraint of being confined to bed. We may have seen the reverse when a fearful and weak-looking individual displays fortitude in face of disaster and disability.

Such inherent qualities, which may be measured by a simple test, are important determinants of personal reaction to pain and stress. However, there are many other important factors that we cannot measure. Perhaps the bodily state of well-being, the mood or the presence or absence of fatigue are of significance. Duff Cooper, in his biography *Old Men Forget*, attributed his courage in battle during World War I to exuberant good health. In any case, we must not rely on externals of appearance, social status or vocation in predicting a possible reaction to disaster and disability. Fortitude and character are where you find them. These desirable qualities, some of which are transmitted from generation to generation according to laws of heredity, are not bequeathed equally to all members of the same family — not even to both members of a set of twins. They are present, however, in peasant or landlord, in the rich or the poor, in the clever or the dull.

The quality of intelligence may be very helpful in adversity, though by itself it does not suffice. Fortitude on the other hand will carry a person far, with or without high intelligence. Sometimes stubborness, a dubious asset in certain circumstances, is alone responsible for a good performance. Anger and hostility, when roused, can be put to good use. In fact, a disabled person in whom we cannot rouse some spark of anger is likely to remain dependent. Then, there is common sense or judgment, a most valuable attribute, possessed by some at such an early age that surely it must have been inborn. Some persons experience more severe emotional reactions than others, as though the emotions were constitutional in origin, though, of course, they may be modified by experience and education.

Evaluating Disability

The severity of disability is an important consideration in the estimation of the effect on the whole organism. Loss of special senses such as sight and hearing, loss of several limbs, loss of speech production, impaired mentality or spinal cord disorders are among the major catastrophes. However, a better way to evaluate the disability is to consider not the severity alone, but the type and extent of persisting impairment. We may thus classify physical disability in accordance with the resulting impairment in three areas.

The first is impairment in the realm of locomotion. The second area is loss of the upper extremities or loss of control over them. The individual is deprived of the ability to express the skills of the mind that are essential for diversion, for vocational activity and, in part, for communication. The third area, impairment of communication, includes speech loss, loss of special senses or loss of the use of the upper extremities.

Most physical disability is reflected in one of these areas. Rehabilitation measures designed to overcome physical deficits are concerned largely with restoring these functions or circumventing the deficits.

Although there is no gainsaying that a serious physical disability is worse than a minor one, and that it is one of the self-evident facts of life that the person with both legs off is more seriously handicapped than someone who has lost but one leg, the severity of a disability can only be determined by considering it in relationship to the person having the disability. The pattern of life of the casualty and the extent to which the impairment forces curtailment of usual activities, is frequently more significant than the actual pathological process. Thus, the loss of a leg is a great handicap to a postman, a high steel worker or a professional athlete. The same impairment might not significantly alter the life pattern of a draughtsman, an accountant or a writer of best sellers.

To a certain extent, the manner in which a disability is acquired affects the person's acceptance and adaptation to it. Disability acquired in defense of our country is sometimes a badge of honor, whereas the same impairment

acquired through folly or unacceptable social behavior may be more difficult to bear. For some, disfiguring disorders are appalling. To others they are of little concern. The loss of a limb may be but an inconvenience. On the other hand it may represent impairment of body image and is, as such, a source of life-long torment.

Meeting Needs

With these thoughts in mind, let us turn to the problem of persons who are sick and disabled. All sorts of people of all ages and from all social backgrounds suffer from all types of disabling diseases and injury. We can be assured of a great variety of problems. The responsibility of doctors and nurses is to meet the needs of those requiring treatment.

The most pressing requirement is to establish, with accuracy and precision, the exact nature of the disorder. This constitutes *diagnosis*. It may require a great deal of study, many tests and some discomfort to the patient but it remains the first essential. Without it proper management of the patient is impossible. All who are associated with the care of the sick must appreciate the importance of this step. When we lose sight of it we soon become confused, fail to establish correct and proper goals and the patient does not receive the best of care.

Following diagnosis comes the second step which is *definitive treatment*. This is the part of the process that minimizes or abolishes the disease or disability. It is the part of medical care in which the patient and his family are most interested. In actual fact, the patient is not too concerned about the diagnosis. If he does learn the name of his disorder he is not likely to appreciate its significance. However, he *is* concerned about his response to treatment. He is fearfully concerned about any possible residual disability that may determine his effectiveness in the daily round of living. The patient pins his hopes on the doctors' skill and ability to effect a cure. Where treatment falls short of the ideal, the patient is faced with the dread necessity of living under the shadow of a physical handicap.

The third important measure is *evaluation*. It is important, after having diagnosed the cause and applied treatment, that the persisting deficit should be measured. This is not in terms of the length of the amputation stump or the names of the paralyzed muscles, but in terms of the effect that it will have on day-to-day living. This is the value of relating disability to impaired function on a simple basis, in terms of locomotion, skilled use of hands or communication.

Interpreting Results

It is simple enough for doctors and nurses to understand that the loss of a leg, paralysis of leg muscles and arthritis of the hip joints, will impair locomotion. The extent of the impairment is not always as easily perceived *by the patient* who may overestimate its importance. The limitation of locomotion resulting from heart disease, a stroke, or simple obesity, is just as real but even less clearly perceived by the patient.

It follows that evaluation requires interpretation so that the patient, his family, employer and friends will be acquainted with the extent of the impairment. It must not be underestimated or overestimated. It must be related to the patient as he is and not as we might like him to be. We must, in other words, put ourselves in the patient's position when trying to evaluate his problem. Evaluation of the defect alone is not enough. We must discover and point out to the patient his remaining assets. We must try to restore function. In instances of impaired locomotion, restoration may be achieved by fitting with and training in the use of artificial limbs — with emphasis on training — or by bracing weak limbs. Perhaps locomotion must be achieved by a wheelchair. It may be that it will be restricted even with the best of care and management.

The patient may not realize or readily accept these realities. The realization may dawn slowly. Extra patience is required, on the part of doctors and nurses, with those who are reluctant to accept reality. It is easier, for example, for a patient to recognize the loss of a limb as a permanent deficit than paralysis of a limb where the structure persists and may be seen and handled. Sometimes, understanding of his deficit does not come until

the patient has been allowed up, has tried to function, and has had a chance to explore the world around him. Equally important to physical treatment is the need to keep hope alive. We are all sustained by our hopes, hence the vital importance of nourishing and supporting them. What is depression of spirits but loss of hope? Who is better able to sustain hope than the doctors and nurses who have the knowledge of what can be achieved, as well as of how it can be done?

Recognition of the significance of loss of control of the upper extremities and of the resulting impairment of the ability to express and practise the skills of the mind is less readily grasped. If the upper limbs are amputated or fearfully mangled, the patient will recognize his deficit. However, if there is paralysis, and the general appearance of the limbs is maintained, the perception is less clear. When the impairment takes the form of sensory paralysis without significant motor impairment, the patient is undergoing an experience which is probably quite beyond his comprehension. He does not have advanced knowledge of the existence of such a deficit or of its implications. This emphasizes the need for careful evaluation and interpretation.

We must give some thought to the significance of the skills of the mind that we acquire as we develop and mature and to the significance and meaning that they hold for us as persons. We must appreciate, for example, how important the ability to play the piano or to sing may be in determining the position we hold among our community of friends and acquaintances. We must be aware to what extent our dependence on the skill of painting, typing or playing tennis is responsible for the maintenance of our self-respect and esteem.

Communication Loss

The loss of use of our upper extremities very quickly deprives us of the ability to express the skills of the mind. These skills, instead of being a source of pride and satisfaction, and indeed a source of livelihood, become a source of frustration leading to bitterness and unhappiness. The skills diminish with lack of practice. Their possessor loses the brightness of personality that is the product of physical and mental activity channelled into purposeful pursuits.

The impairment of the ability to communicate with other people, imprisons the victim within his body, as surely as though he were confined in a prison cell. Communication is dependent on our special senses of sight and hearing, our ability to conceive and execute the spoken word and to interpret the symbols of speech which are words spoken or written. To a degree, we communicate through writing. The written word cannot be committed to paper if there is impairment of the upper extremities. Here again, the management of disabilities of the upper extremities, speech and mind require diagnosis, specific therapy and evaluation of the deficit.

Personality and Intellect

The evaluation of the *deficit* is usually carried out by the medical profession with greater skill than is the evaluation of the *type of person* who suffers the deficit. Nevertheless, we all become fairly competent as doctors and nurses in assessing people, in determining the quality of the intellect and the character they possess. There are important sources of assistance in the evaluation of personality and intellect on which we must draw. I have in mind psychological testing; the study of the social structure and background from which the patient comes; consideration of his past performance. The psychological tests may determine intellectual potential. Personality deviations and emotional conflicts may be revealed in greater detail than can be determined by simple interview techniques. Organic deficits in brain structure may be uncovered and related to personality disorders that have been observed in patients who have suffered severe head injuries. Their poor performance may have been attributed to laziness or apathy and such testing may exonerate them.

Sometimes, but not always, knowledge of previous performance at work or in the domestic field is of value in predicting performance after disability has produced limitation of capacity. It is for this reason that inquiry into the social and work history may be of

vital importance. The rapidity with which a disabled person masters the activities of daily living has shown a close correlation with ultimate restoration to a vocation.

Toward Independence

When all investigation has been completed, we are still faced with making the best of the situation as it exists. We must exert our efforts towards achievement of the highest degree of accomplishment possible through whatever means are available. The best methods are still skilled medical and surgical care supported by first-class nursing care. The details of restoration run the gamut of physical restoration, provision of prostheses, speech therapy, vocational counselling and guidance, and job placement.

In the midst of this variety of activity the nurse endeavors to maintain an exemplary nursing service. It includes skilful, patient practice of familiar nursing techniques. Yet nursing entails more than techniques. Nursing, with the ultimate rehabilitation of the patient in mind, frequently requires that the practice of these skills be gradually withdrawn from him, with tact and encouragement, so that he may regain independence. This must be achieved without making the patient resentful. In actual fact, it is accomplished hundreds of times every day with great tact, skill and diplomacy. It is perhaps the essence of rehabilitation and of good nursing, but it has gone largely unrecognized. Indeed, perhaps it is better so, for in essence, this is not fundamentally different to the requirements of bedside nursing of any type of illness.

There are some differences, however. The prolonged period of hospitalization faced by many of the chronically disabled introduces certain difficulties not encountered when nursing patients with acute short-term illnesses. It is, for example, quite difficult to keep the ultimate objective in mind when dealing with a patient whose day-to-day and week-to-week condition does not change perceptibly. The ability to see any slight progress in relationship to the ultimate goal, requires a certain type of outlook not possessed by everyone. Perhaps it is more likely to be a quality found in mature persons — usually those who have had experience of life, regardless of their age.

It is noteworthy that, on speaking to men and women who have experienced serious and permanent physical disability and who, after a time have learned to cope with life and have even created a new life, that the turning point toward accomplishment is often some simple conversation with a nurse in which she expressed confidence in the patient's ability to perform successfully. It is the result of the impact or influence of one personality on another when one of the individuals concerned, the nurse, is dedicated to the welfare of the other, and possesses the skills that are essential to his well-being. Neither good will nor skill alone is enough. Skill without dedication to another's welfare may keep the body clean and wounds free from infection but will not inspire the disabled to high achievement.

A case which seems to illustrate the intangible in good nursing care is described in language of Biblical simplicity in the records of the pathology museum of the Banting Institute.

> A 65-year-old woman died in July, 1948. She had been paralyzed for many years. As a very young woman she attended a lacrosse match with a young man. Another man, who aspired to her company, appeared with a gun, shot her escort, shot her through the spine and killed himself.
>
> The record reads: "She was sent home to die. With the help of a nurse, she learned to care for and support herself." And this she did for 48 years!

This nurse was a successful practitioner of rehabilitation.

What are the writer's tools? A wide range of language, for variety and to avoid the commonplace; active verbs, to keep the action moving; similes, which make words paint a thousand pictures; metaphor and parable to make meanings clear, and rhythm, which contributes to smooth, easy reading.

— *The Royal Bank of Canada Monthly Letter.*

The Nurse in Rehabilitation

JEAN E. MACGREGOR, B.N.

"Best use of the patient's abilities is made only when restorative care starts early . . . when deformities and other complications are prevented and the patient is keeping his strength through early activities, the confinement will be shorter, the most will be less, and the patient will return more quickly to independence.[1]"

When, Where and Who

A PRACTICAL consideration of physical rehabilitation raises three questions. When should the process of restoration start, where should it be carried out and who is responsible for initiating the program?

The answer to the first one is, when the patient first comes under treatment. This may be in the doctor's office, the patient's home or the hospital. The tendency in the past was to link rehabilitation with the late phases of recovery from illness or injury. This meant that remedial measures were frequently started too late for maximum benefit. In addition, unnecessary complications such as muscle wasting, partial or complete loss of joint motion and loss of bowel and bladder control, could develop during the period of delay. These extra disabilities limited to an even greater extent the degree of recovery from the initial handicap. Modern thinking recognizes the fact that, to be most effective, restorative measures must start early.

Except in the case of the grossly disabled who should, if at all possible, be referred to a rehabilitation centre, the program could be carried out in the patient's own community using available facilities and possibly, in his own home. This is the feeling of authorities after consideration of present physical resources and personnel, the various factors that stimulate a patient's response and the economic aspects of long-term illness. Discussing the care of one category of the handicapped, Dr. Howard Rusk, professor and chairman of the Department of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Centre, states that:

> For the average hemiplegic, adequate training can be given in a general hospital, in a doctor's office or even at home. He does not need a rehabilitation centre.

Since only a limited number of communities presently have specialized services such as rehabilitation centres, departments of physical medicine and associated paramedical units (physiotherapy, occupational therapy, etc.), it is obvious that nurses and doctors must be prepared to assume responsibility for rehabilitation to the limit of their resources. Of these two professional groups, which one is likely to be responsible for initiating the restorative program? In many instances, regardless of whether or not specialized services are available, the nurse will have the best opportunity to begin the work of rehabilitation. She cares for the patient during the critical period of an illness when he is unable to benefit from the more specialized efforts of other members of the team. Since the rehabilitative techniques that she uses are also part of nursing care, the program under such circumstances really starts with her. It is understood, of course, that she will be guided by the patient's condition and the doctor's approval in her choice of nursing measures.

The Nurse's Personal Qualities

The nurse in rehabilitation must have certain special qualities to practise successfully. Most important of all is her philosophy of nursing as related to the care of the handicapped. She must have a sincere belief in the value of and the need for rehabilitation. She must be firmly convinced that restorative measures are worthwhile in the care of all patients regardless of age, type or extent of infirmity. Such personal conviction will determine her attitude towards the handicapped and the effectiveness of her efforts on their behalf.

She needs a deep understanding of

people and an appreciation of the various ways in which they may react to disability. In this respect, maturity in terms of experience with people and not in years necessarily, can be a definite advantage. The nurse must avoid the pitfall of overprotectiveness remembering that her aim is to help her patient achieve the greatest degree of independence possible. Warmth, enthusiasm, gentleness and patience are very necessary attributes as well. They help to win cooperation and give courage to the apprehensive, discouraged patient. The nurse needs extra depths of patience to be satisfied with small gains in improvement herself and to help the patient overcome his frustrations and disappointments.

Imagination and a degree of inventiveness can be very helpful. It has been suggested that the use of "gadgets" for the handicapped has drawbacks.[1] The gadgets may not be practical in the home environment. An imaginative adjustment in familiar surroundings may contribute to a greater degree of independence and resumption of a more normal pattern of life. These particular qualities have special significance for the visiting nurse but apply to the hospital nurse as well since her ultimate aim is to help restore the patient to his home and community.

The successful worker in rehabilitation — nurse, doctor, physiotherapist, etc. — is a dedicated person. She is also professionally competent and dexterous in the techniques of her vocation. Helping the handicapped is, in many instances, a lengthy process with frustrations, disappointments and discouragingly slow results. Success depends on conscientious, determined, persistent efforts whether it involves teaching the use of an artificial limb; re-educating affected muscles or re-establishing communication with the aphasic.

Finally, the nurse must recognize her own limitations, must know when to ask for help and do it quickly enough to permit the patient to benefit from skills other than her own. She must remember that she is only one member of a team.

What the Nurse Does

The rehabilitative techniques used by the nurse are frequently simple nursing measures — so simple that she may not have thought of them as part of rehabilitation. This implies a need for an imaginative change in our way of thinking. How competently and how conscientiously these early measures are carried out can determine later success substantially.

Let us take as an example the patient who is hemiplegic following a stroke. The nurse's positive, optimistic approach to his illness and its problems may be the first assistance that the patient receives from her. The nurse has every reason to expect good or even complete recovery. She must communicate this same optimism.

On the practical level, we think in terms of frequent change in position and meticulous skin care to prevent decubiti and the possibility of an unnecessary and uncomfortable session of skin grafting; a foot-board as a deterrent to footdrop and the need for orthopedic surgery; a bedroll to prevent outward rotation of a paralyzed leg; passive full-range motion of joints to preserve function, and so on. We should think, too, in terms of getting the patient out of bed as soon as his condition permits thus discouraging the tendency to become bedridden. These, and the numerous other measures that might be mentioned, have a very familiar ring but the fact remains that they must be considered as the first steps in rehabilitation.

It is so easy for the nurse to allow the handicapped person to become dependent that she must continually remind herself that the ultimate aim is independence. She can often contribute more by standing aside and letting the patient struggle to comb his own hair, dress himself, feed himself or even talk (in the case of aphasia). She must, of course, be able to recognize the point at which she should start to withdraw her services and the patient must understand why it is necessary.

If the nurse does her part well during the early and critical stage of illness, then the patient can move on to the specialized techniques of the rehabilitation centre or the department of physical medicine and associated paramedical services in a condition to achieve the greatest benefit. The nurse's responsibility does not end

here. For success in this area, the techniques learned in these departments must be practised on the ward or in the home under the nurse's supervision, as required. Rehabilitation is a *team* effort. The nurse must be aware of what the other members are helping the patient to accomplish.

Rehabilitation involves extensive teaching duties as well. If the patient is being cared for in the home, the members of the family may have to be taught nursing measures related to skin care, positioning and so forth. They may need help in making certain improvisations in equipment. This could very well be part of a predischarge program from hospital. Student and graduate nurses will require interpretation of the needs of the individual patient and possibly instruction in some of the techniques. Of course, the patient himself is the prize pupil. Finally, we must not forget the general public who must be helped to see the value of rehabilitation; who must be educated to the use of rehabilitative services; who must be convinced of the economic worth of the handicapped worker. The nurse has a real responsibility in this area.

Conclusion

Rehabilitation is worthwhile. Quoting Dr. Rusk again "... independence and dignity are man's priceless heritage." Physical disability can rob the individual of both. The 1959-60 annual report for the Rehabilitation Institute of Montreal notes that Canada has more than a million handicapped persons. Nearly half of this number have severe and permanent disability with three per cent of the working population, 15-64 years of age, depending on their families or the public for support. Rehabilitation has become an economic and humanitarian necessity.

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STOP PRESS

ALICE M. GIRARD, immediate past president of the Canadian Nurses' Association, has been named by Prime Minister Diefenbaker as the nurse member of the Royal Commission on Health. The aim of the Commission, as stated by the Prime Minister, is to make "a comprehensive and independent study of the existing facilities and the future needs for health services for the people of Canada and the resources to provide such services; to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians."

Miss Girard, who is director of nursing and assistant administrator at St. Luke's Hospital, Montreal, was a speaker at the plenary session of the recent ICN Congress in Melbourne, Australia. Her address will be published in our *Journal* next month.

(G. Carpenter)

ALICE GIRARD

THE REHABILITATION CENTRE

GUSTAVE GINGRAS, M.D.

"... for those who seek through rehabilitation to demonstrate that man's mission on earth is to heal and not to hurt, to build and not to destroy ..."
HOWARD A. RUSK, M.D.

THE REHABILITATION CENTRE is a relatively new type of institution, quite distinct from the general hospital and other specialized facilities such as convalescent homes. Its role lies in that interval between acute illness and return to normal living. It offers the hope of achieving the highest degree possible of physical, psychological and socio-economic recovery. Its services are extended to patients in various categories of illness who have passed the critical stage. However, the main work of such a centre revolves around the grossly disabled — the amputees, paraplegics, hemiplegics and victims of poliomyelitis. Recovery, in the disabled, depends upon methods of re-education, specialized treatments and compensatory mechanisms especially in cases of irreversible damage.

Contemporary demands for rehabilitation are more clearly obvious if placed in an historic perspective. This third phase of medicine has assumed sufficient prominence to give the impression that it is a 20th century innovation. However, even in the Renaissance era the work of Ambroise Paré with war casualties and the prosthetic devices that he perfected for the amputees — artificial arms, crutches — testifies that medicine has been concerned about achieving the best possible recovery following illness and improving the condition of the physically handicapped over a long period of time. The practice of rehabilitation has been completely transformed by the two world wars.

Development of Physiatrics

Physical medicine has undergone extensive development, become more and more clearly defined and has emerged as a distinct medical specialty. The field of interest of physiatrics (physical medicine and rehabilitation) comprises diagnosis of conditions of the locomotive system in particular, medical treatment using physical means principally, and complete rehabilitation of the patient. Physiotherapy and occupational therapy are the chief resources of physiatrics. Their techniques are usually carried out under the guidance of a doctor by specially trained technicians. Both of these paramedical professions came to the fore in much the same way as physiatrics and have continued to develop.

But the war and post-war years have taught us more than this. The social rehabilitation of the war crippled, civilian or military, was not an easy matter. Communities felt that their very existence was threatened by the number of handicapped for whom they had to assume responsibility. It was no wonder that every possible facility was utilized that could contribute to the salvage of the infirm and their placement in the working world. Government, industry and voluntary organizations strove to find efficient means to develop the potential of the disabled population so that they could take an active role in society. The results far surpassed the hopes of all concerned.

Physiatrics opens the way toward improvement in many areas. Industrialization has transformed the work market in such a way that additional opportunities for the handicapped have been made possible. Elaborate division of labor and specialization, characteristic of industry, have changed demands for labor radically. Work physiology and industrial psychology have brought to light the fact that most of us have to develop a variety of

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skills in order to carry out a job. Reclassification of the handicapped is seen in a different perspective. In many instances, the disabled have been hampered more through lack of orientation, loss of faith in the future and the preconceived ideas of those around them than by the nature of their handicap.

The techniques utilized for half a century in the scientific care of people, contribute in no small measure to rehabilitation. To determine the prognosis of rehabilitation, evaluation of the seriousness of physical incapacity is not enough. The patient's reaction to his handicap, his intellectual acuity, his former potential, his pattern of behavior, the strong points in his personality, his general development and positive factors in his environment are determinant forces. Rehabilitation often proceeds along several planes at the same time throughout the course of treatment since medical, emotional and social problems are constantly cropping up.

The Rehabilitative Process

Whether it is a congenital or an acquired infirmity, the first step in an individual's rehabilitation is a re-evaluation of himself. The way in which the handicapped person sees himself and his environment in relation to himself is basic to his personal motivation and determination to rise above his physical deficiencies and resume normal living. Physical improvement, the prospect of achieving independence in regard to personal hygiene and moving about, the hope of attaining economic self-sufficiency and personal satisfaction from remunerative work are, in themselves, very powerful motives. However, they leave the patient very vulnerable to a certain feeling of physical let-down and discouragement if he does not receive outside support.

The handicapped individual does not live in isolation. It would be fantastic to consider rehabilitating him without considering the influence of his family, his social milieu and his complete technical group. These are, in short, all the points of social interaction that must be taken under consideration. Quite naturally one thinks of the problems facing the family. In many cases close relatives require assistance through extensive interpretation and must be helped to find the routine of life that will be most satisfying for the whole household. They must be made aware of available community resources where help can be had as required.

(Graetz Bros. Ltd. Montreal)

Assisting the amputee

Job placement can not be left to chance. It may be that the patient requires vocational guidance and a planned introduction to his future work if he must give up what he has been doing previously. Placement bureaus can bridge the gap between the demands of the jobs available on the labor market and the abilities of the individual. Finally, it is society as a whole, the state, the general public, manufacturers and leaders who must incorporate rehabilitation into their thinking if physiatrics is to have the appeal and receive the recognition it deserves.

The role of hospitals in rehabilitation is not under examination here, important as their contribution is. Physical medicine is indicated long before the disability is firmly established. Motor rehabilitation begins as soon as the patient's life is out of danger. This determines to a large extent the results of total rehabilitation. The services of physical medicine and rehabilitation within the general hospital are directed mainly to persons who do

(Graetz Bros. Ltd. Montreal)

Learning to use crutches

not require long-term treatment or who do not need the help of a full team. Patients from other hospital units who can not be shifted about can receive their treatments at the bedside. However, those who are ambulatory or who can be transported in some way must go to the department for daily training. Hospital facilities of this type permit paraplegics, hemiplegics and others with long-term conditions to remain in hospital until they have recuperated sufficiently, physically or psychically, to be transferred to a rehabilitation centre. If the handicap is of a temporary nature, the patient attends the outpatient clinic. It is obvious that someone with transitory disability who must resume normal living and a return to his means of livelihood does not have to remain in the centre. On the other hand, the severely handicapped individual who very probably will never resume all of his former activities must undergo an entire battery of tests. Victims of brain injuries, cerebral palsy, severe poliomyelitis and hemiplegia whose recuperation is lengthy, should be directed to rehabilitation centres.

The services offered should include, in addition to the customary administrative division, gymnasiums, hydrotherapy, massage, manipulation, electrotherapy and an occupational therapy department. The latter should provide activities that have been adapted to problems encountered in general and children's hospitals and psychiatric units. In addition, there must be provision for speech therapy and audiology. Medical and social services have a contribution to make as well.

The personnel and the services of a rehabilitation centre must be considerably more complete than those of a department of physical medicine in hospital. In any properly organized rehabilitation centre, the services are united under the direction of a specialist in physical medicine and rehabilitation in consultation with other specialists in medicine and surgery, physiotherapy, occupational therapy, hearing and speech, nursing, prosthetic services, educational and vocational guidance, child education and job placement. The simplest yet most essential requisite is coordination of all rehabilitative services into an integrated program under a single medical authority.

Rehabilitation is *more* than a discipline. It is a bond between the diverse disciplines that combine according to the requirements of individual cases. During the rehabilitative phase, the energy and the strength of the patient are not being sapped by his struggle against illness. Consequently, he can devote himself completely to the business of getting well. To help him do so several specialists combine their knowledge and skill so that he may have the best of their collective care. However, this distribution of work is meaningful and effective only if everyone, including the patient, works together as a team. Rehabilitation depends on active participation by the disabled person.

The Rehabilitation Centre

Designs for a rehabilitation centre must always take into consideration the fact that a large proportion of the disabled get about with artificial limbs, crutches, wheel chairs or stretchers. Consequently, access to all areas must be made as easy as possible and obstacles reduced to a minimum to eliminate possible causes of accident. Sloping ramps to entrances and floors must be covered with non-skid surfacing to avoid falls. Means of communication along vertical as well as horizontal lines assume primary importance because patients must learn to get around

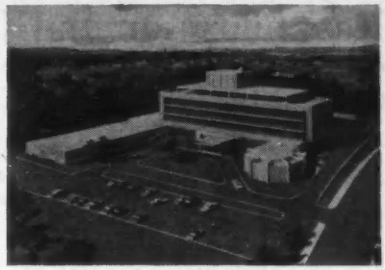
gradually. Most of them must go from one unit to another in the centre to receive treatment.

Bathrooms must be sufficiently large to give access to patients with prostheses, crutches or in wheel chairs. It is even advisable to provide for a large bathroom adjoining each room in the in-patient area since establishing bowel and bladder control as well as mastering the activities of daily living — combing one's hair, bathing, dressing — comprise an important goal of rehabilitation for the severely handicapped.

Space distribution in the centre is carried out in an entirely different manner than is done in general hospitals. As a general rule, inpatients do not remain for long periods of time. Their treatments are designed to encourage them to participate as outpatients so that they may resume comparatively normal living as quickly as possible. This means that the number of beds required can be comparatively limited. On the other hand, the centre needs large gymnasiums, treatment areas, a swimming pool and work rooms of all kinds. The units should be bright and sunny. The decor should be such as to produce a pleasant, gracious atmosphere. Everything must work together to help restore the individual's taste for living.

Taking everything into account, the cost of treatment in a rehabilitation centre is relatively small. Hospitalization charges are minimal since so few patients must be resident. Outpatients outnumber resident patients three to one. The centre does not have to include in its budget the high cost of maintaining operating rooms, radiology facilities and various other services essential for the general hospital. A single rehabilitation centre can reduce congestion in several general hospitals and can be constructed for a fraction of the cost of the latter. The chronically ill and long-term patients who literally paralyze the general institution and who eventually become objects of indifference, can recover comparative independence thanks to rehabilitative treatment.

Some disabilities are very rare and do not justify maintenance of special rehabilitation units and personnel in individual hospitals. The use of the



(Arnott & Rogers, Montreal)

The Rehabilitation Institute of Montreal

centre permits the general hospital to fulfil its own role and provide for rehabilitation under the most favorable conditions. Apart from the economy that results, there are implications for the national economy as well. Both economists and administrators have realized the need for enlightened, functional, total plans of rehabilitation. It has been estimated that two out of every 100 Canadians live at the expense of their families or communities as the result of physical disability. Since road accidents, industrial mishaps and chronic illness seem to be characteristic of our way of life and its increasing life-span, this burden of disability could assume crushing proportions 20 years from now. The function of rehabilitation is to help the patient to adjust to his environment gradually, to become as independent as possible in regard to personal needs, to regain his status as a contributing member to, rather than a burden on, society. The cost is negligible when compared to the addition to public funds through taxation when the former invalid returns to work.

This economic aspect has been one of the most powerful influences in the development of rehabilitation and has led to the establishment of centres. However the effect of rehabilitation is felt at other levels as well. A United Nations communique notes that it leads to public understanding and motivation; it produces high ideals in social progress; it breaks down the barriers that society tends to set up against those who are different. In all, work on behalf of the handicapped represents an important contribution to the well-being of mankind.

Rehabilitation and Job Placement

LAURETTE SÉNÉCAL

The ultimate aim of rehabilitation is restoration of the individual as a productive member of society. Therefore, the task does not end in the gymnasium or treatment rooms of the rehabilitation centre.

HAVE YOU EVER ASKED YOURSELF what would happen to you if, suddenly, as a result of sickness or an accident you found yourself handicapped for life? If a member of your family or a friend were suddenly afflicted, and you were called upon to advise him on how to earn his living as a handicapped person, what would you do? Where would you refer him? Perhaps you have never had to face this problem. As professional nurses, you are undoubtedly aware of the treatment required, from the standpoint of hospitalization, for physical and mental rehabilitation. But the task of full rehabilitation is not complete at that point.

Within his family environment and at other social levels, the handicapped person must face problems every day. He must not be made to feel that, because of his infirmity, he has become entirely dependent.

From personal experience gained through helping handicapped persons to meet the problems of everyday living, I have gained much information that may be of help to others in a similar situation. For example, I have learned that the National Employment Service of the Unemployment Insurance Commission offers many advantages and opportunities to handicapped persons to help them attain their economic independence. The placement officers could have helped in the following instance.

Over 10 years ago, a young Montreal man had a severe bout of virus pneumonia. In spite of assiduous, conscientious treatment, the pneumonia was followed by acute progressive meningomyelitis (Landry's paralysis).

The use of antibiotics saved his life, but to the end of his days, he would be an invalid who could get around only with the aid of a wheel chair. As part of his care he was treated by Dr. Gingras, executive director of the Rehabilitation Institute of Montreal.

After treatment, he returned home and remained inactive for a long time. This delayed his resumption of a normal life and business career. Ten years ago, there was little possibility for a handicapped person to earn his living, regardless of his academic, professional or technical attainments. The ideal of hiring a badly handicapped person was not a pleasant prospect for most employers.

The patient completed his studies in accountancy and finally obtained a position as comptroller in a private company. After a year, he was ob'iged to leave his employment and ever since then his physical condition has deteriorated. For several months he has been bed-ridden.

If, between the period of his medical rehabilitation and his return to gainful employment, those responsible for his care had known of the existence of the Special Placement Officers of the National Employment Service, the life and the problems of the members of his family would have been eased considerably.

It was during a period of observation in public health work and industrial hygiene in the city of Toronto, as part of my postgraduate experience, that I first learned of the existence of this service. Upon my return to Montreal, I had the privilege of meeting the local representatives of the National Employment Service, with whom I discussed the problems of this patient.

My efforts on behalf of him as well as others gave me the opportunity to discover another very active organization in rehabilitation work within this area

Miss Sénécal, a public health nurse, represents the Health Department of the City of Montreal on the local Council for the Guidance of the Handicapped. She is also the honorary secretary and liaison officer for the executive committee of the same body.

— the Montreal Council for the Guidance of the Handicapped. The council is a benevolent organization that works in an advisory capacity to the National Employment Service of the Unemployment Insurance Commission. Its members represent employers' associations, labor unions, social organizations interested in medical rehabilitation, public health agencies and professional workers in the placement of the handicapped.

The National Employment Service has offices throughout Canada. Special placements sections exist in all offices in Montreal and throughout the province of Quebec. These divisions are staffed by counsellors who have had special preparation in the placement of handicapped workers at every level of industry.

To carry out a satisfactory placement following medical rehabilitation, the Special Placements Officer must obtain, among other information, the medical case history as well as the record of academic, professional or technical training of the candidate. Technicians who are skilled in the art of giving psychometric tests are called upon as the occasion warrants.

A survey made by the Rehabilitation Committee of Montreal and published by the Sun Life Company of Canada in 1949, stressed the great importance of the placement of handicapped workers as the final act in the complete rehabilitative process of the disabled. From this report, we have been able to grasp an idea of the tremendous task that is accomplished by the Special Placements Officers. For example, in Montreal, 3,100 persons handicapped in various ways, were placed in suitable employment during the year 1960. Across Canada, during the same period, a total of 17,940 handicapped applicants obtained gainful employment. The following excerpts from official records indicate the type of help that is given:

1. A married lady, 45 years of age, a chronic alcoholic, had been placed five times within three years by officers in Special Placements. She was a well-qualified and competent bookkeeper, but she lost a number of positions due to absenteeism. As a result of physical impairment, she was obliged to walk with a cane. She was placed finally as a bookkeeper on a temporary basis. During the "Employ the Handicapped Week," she visited the Special Placements Officers with a view to bettering her position. On advising her employer of her intentions, she was taken on permanent staff at a good weekly salary. Her employer reports that her condition is much improved and that she is giving the firm valuable service.

2. A married man, 55 years of age, deaf, unable to speak but who was a lip-reader, became a specialist in the operation of a certain machine in the boot and shoe industry. After working in this type of work for a number of years, he was unable to cope with the stress of the required production since it had brought about additional personal problems. Unable to find other work on his own, he applied to the Special Placements Officer in his area. After many employer contacts, he was successfully placed in a luggage manufacturing concern. He is now on permanent staff, happy in his work, and functioning to the entire satisfaction of his employer.

It has been proven through surveys and comprehensive studies both in Canada and the United States, that considerable sums of money have been saved through the placement of disabled persons. In Canada, a study of 427 cases showed that 228 of these people were receiving public assistance or benefits from various welfare organizations to the amount of $230,000. The national coordinator for the Rehabilitation of Physically Handicapped Persons, Mr. Ian Campbell, reported the following: "In the first year of their employment, these same rehabilitated persons earned $950,000, and I know of no greater investment."

Publicity campaigns, known as "Employ the Handicapped Week" are held each year. The purpose is to draw the attention of the general public, but especially of prospective employers to the work of the Special Placements Officers in finding suitable employment for competent, although handicapped, workers.

Several practical and informative brochures have been published, such as "How Old is Old" which gives an up-to-date exposé of the problems faced by ageing workers. Another one is entitled "National Employment Service." This outlines what the Service is doing in the field of employment in

Canada. These booklets can be procured free of charge by writing to the Director of Public Relations, Unemployment Insurance Commission, Ottawa. In the public relations department of the National Employment Service there are liaison officers who are at the disposal of groups or service clubs that are interested in learning about the problems of placing the handicapped workers of our country.

Interesting films entitled "Date of Birth," "Everybody's Handicapped," and "Call it Rehabilitation" are also available for the information and education of interested persons. These films may be obtained by applying to the National Film Board, 3255 Cote de Liesse Road, Montreal.

More professional nurses are needed in organizations similar to the Council for the Guidance of the Handicapped. As they bring their competence, experience and understanding of the human problems of our society, they benefit the community in general, and the handicapped citizens of our country in particular. Nurses have a part to play in encouraging the handicapped to face and surmount their particular problems, and in furnishing them with information concerning how to obtain suitable training and education in their attempt to obtain gainful employment and independence. It is generally agreed by persons interested in the field of rehabilitation that work is the best therapy.

An Integrated Recreational Program

PEGGY C. PIKE

The Recreation Committee has surmounted the subtle barriers between disciplines. It has become a productive team dedicated to the welfare of the psychiatric patients under its care.

EARLY in the history of the Allan Memorial Institute, Montreal, there was no organized or structured recreational program. The patient's evenings were spent quietly, as it was felt befitted the needs of sick people. The nurses encouraged the patients to play cards or one of the few available parlor games such as Chinese checkers. Television was not part of our passive entertainment, but the radio was much in evidence. It was played loudly or softly according to the wishes of the group in power. Occasionally a head nurse, time permitting, might plan a social activity. These occasions were so few that they passed unnoticed.

Perhaps this state of affairs would have continued, except for two major changes in the hospital. One was the addition of a new wing that increased the population of patients from 63 to 125. The second was the addition of a social group worker, someone who had been specially trained in group work and in planning recreational programs.

The group worker organized weekly evening events that included dancing, sinsongs and games. His success sparked a latent enthusiasm in the other departments of the hospital. The student nurses wanted to organize parties. The student occupational therapists wanted to do the same. This was a little awkward because now there was overlapping. The worker and his volunteers, students from McGill University, housewives, business men and women, found that they were organizing events or socials which, at the same time, were under the direction of another group.

After one particularly confusing evening the Recreation Committee came into being. Members from the teaching department and the occupational therapy department met with the group worker. They decided to combine and organize their social efforts.

Miss Pike is in charge of the nursing research department of the Allan Memorial Institute, Royal Victoria Hospital, Montreal.

A memo asking permission to form such a committee was sent to the director. He was most enthusiastic, gave his consent and asked to be informed of progress.

The Recreation Committee supports the concept that recreation is universal and therapeutic. It also contends that recreation is a shared responsibility. We do not simply present the patients with special dances and parties. The patients share in the planning and carrying through of events. It is not too important if the cookies they make are rock-like, or that the decorations they put up tend to fall down. These are *their* contributions. They have a value beyond anything we could give. Above all, we wish to avoid the over-direction that can only lead to institutional-like activity.

We keep in mind that the patients are temporarily apart from their everyday world and are soon to return. We encourage them to take part in the program in a manner closely related to their normal activities. For example, one patient was asked to pour tea at a reception following an art display. At the close of the evening she reported with great satisfaction that she was relieved to find she could still act as a hostess. Relatives and friends are encouraged to attend the dances and parties. One reason is to lessen the breach between the hospital and the outside world. Sometimes they enjoy themselves so much that they ask when we are going to have another gathering. Frequently they point out that the patients are so like everyone else that they have forgotten they are in a hospital. Today, visiting a patient has become a pleasant and, at times, a social event.

Another reason for including relatives and friends is that they meet many staff members on a social basis. After a period of talking, dancing and refreshments, the visitors develop a warmer feeling for and better appreciation of the hospital world in which the patients spend their days. Such an evening cannot help but dispel any pictures they may have of deranged patients and stereotyped staff.

When the group worker is using musical records that are current favorites he is continuing the principle of closing the gap between the *in* and *out* world. The patient, on discharge, will not regard his hospitalization as a lost period or blind spot.

The Recreation Committee is a representative group of people working together towards definite goals. Their roles are based primarily on the relation to their routine duties. A natural and acceptable division of responsibility has ensued. The group worker has maintained his status as coordinator of the evening program. No attempt has been made to change the basic pattern of evening recreation. The Committee, for example, will choose a routine recreational evening close to a holiday and plan special food and decorations to stress a particular theme. The evening becomes an unusual and entertaining success for the patients.

Structure

The committee in the beginning was composed of the group worker, the nursing instructor and the director of the occupational therapy department. The need to expand was immediately appreciated. Today, in addition to the basic committee members, we have nurses representing the wards plus the dietitian and two occupational therapists. The roles these people play may be specific, but, at the same time, the members combine their efforts to meet the over-all objectives of the committee.

The Recreation Committee

The committee proposed to study the recreational facilities of the Allan Memorial Institute as well as recreation itself. We felt that availability, distribution, care and purchase of new games and sports equipment should be reviewed. To this end we asked the charge nurses to find out what the patients would like. The responses varied from the reasonable to the unreasonable. In retrospect even some of the suggestions considered beyond our scope have been carried through. We do not as yet have the swimming pool as suggested, but we do have an outdoor shuffle board and a standard pool table. We have seen to it that a representative selection of parlor games is on each ward. The supply is replenished whenever necessary.

By continuous checking we know

what the patients like and need most frequently. For example, we have found that they use, at least two packs of playing cards a month, but they do not get much enjoyment out of jigsaw puzzles. Games of general popularity at the moment are the ones preferred. However, after a few months of Scrabble, they immediately changed to Monopoly, when it was introduced to the ward. Bingo, as a form of group entertainment, is a favorite standby.

Summer weather brings a shift of emphasis. Baseball, handball, putting, croquet and shuffleboard take the patients outdoors. At the same time they experience a change, in the psychological sense. In active games, there is physical contact. Competition is more strongly felt and exercised. True, patients compete in a game of billiards, but they maintain a sense of individuality and are not intimidated by the size and strength of their opponents. The passive games are used as a variation by the younger patients and as a choice by the older ones.

The committee is gradually becoming more aware of the deeper meaning and value of active and passive recreation. The group worker, through his training, remains our leader. The information we receive from him, broadens our perspective. We are able to stress the importance of recreation to other members of the staff.

As we learned the importance of recreation, we began to see many aspects that had not been apparent to us earlier. Games are relaxing and, at the same time, a satisfactory outlet for aggressiveness and hostility. Thus, games are therapeutic and meet individual needs. We now appreciate the many types necessary to cover the broad spectrum of the patients' requirements.

Equipment for sports and games must satisfy certain criteria. It must be of good quality and not on the level of toys. Patients who are adults should be respected as such, even in the realm of recreation. The equipment should be kept in good repair. No one enjoys using a broken croquet mallet, nor would we like to spend hours putting an incomplete jigsaw puzzle together. Patients have a right to expect us not to add to their problems with such irritating frustrations.

As the committee became cognizant of the many intricacies of social activities and recreation, it was at the same time alerted to the financial burdens entailed. Extra refreshments for parties, decorations, repair and renewal of games and equipment all added to more than the allowance possible for the hospital to grant. If we were to fulfil the recreational goals we had evolved, the burden was ours.

Either emboldened by our success with patient social events or just courageous on behalf of our cause, we went ahead with plans to raise funds. The principles applied to activating patients were now applied to the total hospital staff. No one was immune. Permission was obtained; subcommittees were formed; all departments of the hospital were soon aware of our campaign. The events that followed proved very successful financially and heightened interest in and awareness of the recreational needs of the patients.

Social Events

Since the advent of the Recreation Committee there has been an average of one large social event each month. The programs may vary considerably, but the basic pattern is unaltered. The Committee decides upon the theme; patient subcommittees are formed; the plans are discussed. The patients' ideas are accepted as far as possible. We have learned that their contributions are invaluable. We have even discovered that very sick patients have responded beyond our first expectations.

When the event reaches its climax, the numbers of people involved are beyond those generally expected at a hospital function for patients. Apart from staff members and volunteers, relatives, friends and ex-patients gather. It is, indeed, gratifying to share the feeling of accomplishment the patients exhibit as a result of their own efforts. All the excitement and satisfaction related to the successful completion of any social event is in evidence.

Some of the unique presentations organized by these means have included a display of the patients' work in occupational therapy, followed by a reception; outdoor summer dances

planned in the style of a cabaret and parties at which one ward was host to the others.

Occupational Therapy Department

The occupational therapy department is represented by two members. Although they work together there is division of interest. One therapist is primarily involved with decorating and poster projects. Meetings are held with the patients and their wishes are respected. Sometimes, the signs and decorations are very skilfully designed, other times they lack polish but abound in enthusiasm.

The second therapist takes on the supervision of baking extra cookies and cakes for parties. Patients who are interested in this aspect of entertainment form a subcommittee under the direction of the staff. The staff members act as support, guide and control. This is necessary since the resources of the kitchen and the budget are somewhat limited. Too many patients trying to cook at once leads to confusion and discouragement. In addition, patients lose track of time or forget to cook because of their treatments or involvement with their problems. The occupational therapist issues gentle reminders when there is a tendency for this to happen. Patients who are members of the sub-committee, do not as a rule get too far away from the reality of the budget. Surprisingly enough, they limit other members of the group who are too extreme in their suggestions.

The concomitant problem of how the food is to be served, is a natural outgrowth. Buffet style is the most favored. Special serviettes, candles, table cloths and flowers are all brought up for discussion. One charming custom has evolved. Patients who have flowers volunteer or are asked by the patients' committee if they would allow them to be used. It is a common thing, shortly before a party, to see the patients from all of the wards, carrying bouquets and potted plants down to the scene of the social event. If tables or chairs need to be moved, a committee of male patients is most enthusiastic about this task. The patients maintain their responsibility for these things to the conclusion of the evening. Flowers are carefully returned to their owners and furniture is put back in place.

Dietitian

This person is a very important member of our committee. Her activities relate in some degree to those of the occupational therapist. She can be found attending the patients' meetings on refreshments. She tells the committee what the hospital can supply, then it plans accordingly. As a rule, she is able to organize her menu to provide enough cake or cookies to supply the patients. Then they approximate the number of visitors expected and attempt to supplement the basic menu.

The Nurses' Role

The nurses have a ubiquitous role in this committee. This is due, in part, to the fact that we make a policy of having a nurse representative from each ward on the committee. By doing this we maintain a direct channel of communication. They report matters of interest and importance to the nurse in charge of the individual floor. The head nurse will direct this information to the other staff members and to the patients at one of their group meetings. If, for example, we wish to arrange a decoration committee the head nurse talks it over with the patients and encourages any interest on their part.

Because the nurse is in continual direct contact with patients, it is natural to expect that she will adopt the role of supporter and stimulator of enthusiasm. She sparks interest in the individual patient according to his probable response to a given situation. She encourages and supports the subcommittees in their efforts.

All students, undergraduate and postgraduate, have seminars with the group worker on the therapeutic value and principles of recreation. These seminars have increased their constructive participation. Now it is the custom for student nurses to arrange their own contribution to the annual Christmas party. In summer, with the guidance of the Recreation Committee they plan and carry out an outdoor social. Any indication of heightened interest in recreation and desire to organize a program is encouraged by the committee. The patients are always

delighted to cooperate with the students. Their energy and frank enjoyment of their efforts seem to infect the patients with a like reaction.

The Recreation Committee has a consultant, the administrative assistant to the director. In common with all committees we occasionally need clarification in matters relating to policy. For instance, we frequently want to publicize an event beyond the confines of the hospital. The consultant can arrange this for us and, by so doing, give official sanction to any newspaper notices. Incidental to this, the patients often see the announcements in the news before the staff and are delighted in telling us about them. The committee benefits in another way from the consultant. We know that we have someone in a key position who is specifically interested in our activities and to whom we can always turn for support.

The housekeeper is not on the committee but only because it is impossible for her to arrange her schedule to attend meetings. Nevertheless, we depend upon her for extra staff to rearrange furniture and to clean up after big events. By giving sufficient notice of our plans the housekeeper always provides the necessary personnel. The maids and cleaners seem to receive vicarious pleasure from the atmosphere surrounding our socials.

When the volunteers are, for some reason, unable to assist in recreation, the student nurses are more than willing to take on the added responsibility. Furthermore, they are successful in their efforts and appear to enjoy themselves as much as the patients do.

Future Aims

This committee has, in common with all committees, future goals. We hope to promote a greater awareness in the staff of the therapeutic value of recreation. The committee sees recreation as a tool to aid in the observation of patients' interaction with other people and the development of their socializing skills.

In time, perhaps, we will be able to arrange specific games to meet the needs of the specific patient, thus enhancing the therapeutic value to the individual. In this manner we may be better able to involve the withdrawn patient and meet the demands of the overactive patient.

Our wish to include everyone in patient recreation may be due, in part, to the amazing changes we have witnessed within the committee itself. The group worker is no longer just the man who conducts the evening entertainment. We realize the intricacies of his profession and the therapeutic value of his program. We have demonstrated to ourselves the advantages to the patients when the occupational therapists and the nurses combine their efforts. The most gratifying result has been the effect on our relations with the dietitian. She is no longer isolated in her kitchen, but integrated, as she should be, in the total effort towards re-establishing the health of the patients. Finally, the committee envisions itself as the core from which research on the effects of recreation may emanate.

Herein lies the tragedy of the age!
Not that men are poor;
All men know something of poverty.
Not that men are wicked;
Who is good?
Not that men are ignorant;
What is truth?
Nay, but that men should know so
little of each other.

— W. E. B. DuBois

* * *

If you want your top pie crust to be extra appetizing, extra short, roll out your top crust and spread it with soft butter. Place it buttered side down on the pie . . . then bake.

Research-mindedness is a readiness to look analytically at the events or working methods with which we are concerned, a willingness to encourage scientific study or experimentation, and an ability to accept the proven conclusions and act accordingly.

— Dr. J. H. F. Brotherston

* * *

Recently, Mount Sinai Hospital, New York City called in an expert from the Handwriting Foundation to stimulate interests in better penmanship, especially among the doctors. If enough doctors sign up, the Foundation will offer a free handwriting course at the hospital. — *R.N.* May, 1961

A PHILOSOPHY OF NURSING

THELMA POTTER, B.N., M.SC.N.

Schools of nursing that are participating in the CNA School Improvement Program, are being asked to submit a statement of the philosophy of the school, if such exists. This philosophy is influenced by the philosophies of nursing of those who formulate it. As individual nurses we each have a philosophy of nursing. Does it guide us?

A NURSING PHILOSOPHY reflects a personal philosophy of life. It is my belief that health is essential to continued growth and development; that ill-health, in any form, retards the growth process and prevents the individual from making a maximum contribution to life — for himself, his family and the community. Health is the right of everyone, not just freedom from disease but the ability to adapt adequately to the usual stresses to which one is exposed without experiencing discomfort, disability or limitation of social capacity. "The health disciplines should help man to free himself from the enslavement of illness and disability, from fear and neurotic restriction."*

My philosophy of nursing gives emphasis to:

1. An appreciation of the cause of dis-ease.

Disease is an interference in harmonious functioning of the human organism which is caused by stress from either an internal or external source.

2. The underlying problem, which is the one of greatest significance.

To recognize this underlying problem is a nurse's responsibility and requires a knowledge of human behavior.

3. The fact that all illness is influenced by environmental factors and all illness has social significance.

The challenge to the nurse is to attempt to uncover environmental factors and assist in reducing the social impact of illness.

4. A comprehensive approach to patient care.

The patient admission to hospital with a disease label provides an opportunity for intelligent appraisal of need as determined by the physical interference and also by the influences of home, family, community, occupation and personal philosophy.

5. The fact that the ability to adapt to the usual stresses of life, without undue difficulty, is dependent upon the security which is established in the mother-child relationship through infancy and childhood.

6. Positive health.

Are nurses motivated to accept too easily sickness and ill-health as a societal pattern? Could more emphasis be given to acceptance of health as a normal pattern and any interference as an indication of other needs?

7. The need for an inner resource.

Adversity comes to everyone. Nurses need a personally satisfying answer to the mystery of the universe so that they can share the resource with those in greatest need — the sick.

Miss Potter is lecturer in Principles of Administration at Dalhousie University School of Nursing, Halifax, N.S.

*Romono, John. Professor of Psychiatry. Rochester, N.Y.

If we do not recognize our likeness in another man, all approaches will be in vain; he will be a stranger to us, and we will remain strangers to him. If we will not love man, to try to educate him will be in vain, and although we may speak the language of angels, our words will be but a little noise.

The peanut, native of tropical America, is not a nut but a legume with seeds developing underground.

* * *

Knowledge is of two kinds. We know a subject ourselves, or we know where we can find information upon it.

— *Boswell's Life of Johnson*

Patients with Long-term Illness

J. R. D. Bayne, M.D.

A great deal has been said and written to the effect that modern programs of education for nurses ignore the traditional skills that were so well taught and practised "in the old days." It is said that the curriculum in schools of nursing today is focused on theory; that nurses are trained to be junior executives, coordinating activities, issuing directives, and reporting on the progress of patients as though they were experimental animals or test-tube reactions.

The attitude described in the heading is, of course, an exaggeration. The patient admitted in critical condition to the modern hospital needs efficient, skilled, scientific treatment. He gets it because the nurses and doctors are highly trained and effective. The patient who tried the skill, knowledge and patience of nurses in former days was the one with long-term illness whose eventual recovery depended largely on careful nursing. With modern techniques many acute illnesses are cured and do not become long-term problems. Our general hospitals are organized now in the direction of rapid efficient service.

Chronic Illness

It should not be thought that long-term nursing problems no longer exist. With the decreased mortality in diseases of infancy and young adulthood, the rate of survival of many more people into old age is increasing. In old age the body is subject to a greater variety of illnesses and these tend to persist longer. Such illnesses are usually referred to as "chronic." Should patients with chronic illness be treated in general hospitals where they occupy hospital beds needed for the treatment of individuals with acute illness?

We should define what we mean by the term "chronic," which is so commonly used and which frequently implies hopelessness. Is a chronic illness one which has failed to respond to prolonged treatment and which may be thought of as hopeless? Or is it a certain type of illness that can be recognized as chronic even when it first begins because it is known to have a prolonged, continuous or intermittent course? If the first definition is correct and a person becomes chronically ill only when he fails to respond to adequate treatment, then it is *essential* that adequate treatment be given, even if it takes months, before the condition is labelled "chronic." If the second definition is correct and a person suffering from a condition such as arthritis or stroke is chronically ill then certainly it must be admitted that the onset may be extremely abrupt or "acute." In either case, such sick people need treatment in hospital for as long as they continue to make progress.

It is common for those experiencing an acute onset of illness to be admitted to general hospitals for diagnosis and early treatment. However if prolonged care is required it may be felt that the patient does not belong in a general hospital although we have just pointed out that he may need, and benefit from, active treatment and should not be sent away for custodial care in a nursing home. One might ask if the treatment program in a general hospital is adequate for such patients or if they have special needs not met in the general medical and surgical wards.

The Pattern of Care

At the onset of serious illness the patient needs careful, attentive, highly technical nursing care. To benefit maximally he is put to bed and becomes completely dependent on the staff for every need, including nourishment and elimination. He returns to the stage of infancy. It it thought this dependency plays an important part in his recovery. With improvement he is

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allowed increasing activity. Many patients are able to judge how much activity to take by their own feelings, or are able to accept controls put on their activity by the nursing and medical staff. Some patients, however, who have been seriously ill are so frightened as a result of the experience that they must be strongly encouraged to increase their activity. A few resist this encouragement through fear or other motives which may not be understood by the staff. Such patients may stir up considerable hostility and be labelled as having "hospitalitis." In the general wards nurses seldom have time to do more than encourage the recovery of independence.

A patient who suffers from a stroke, arthritis or severe heart trouble may be incapable of responding to such encouragement. During the early phase of the illness he was, perhaps, carefully kept in bed, given fluids as ordered, and bed-sides may have been used to prevent accidents. An indwelling catheter may have been inserted. To regain independence such a person requires very active treatment. A physiotherapist and occupational therapist may be available for short periods each day but for the remainder of the day he finds himself alone.

Many people with long-term illness of this nature *can* recover independence but to do so they require *a continuing activity program,* going on throughout the day. The patient must be encouraged and taught to feed himself. He may need self-help devices such as spoons and forks fastened to small splints that can be strapped to his hand; a razor or comb on a stick or splint to lengthen his reach. He will need a low bed so that he can learn to get in and out alone. He must be taught to dress completely, to walk about and to control elimination. To learn this requires hours of practice and constant encouragement from the whole staff. He must be allowed to walk about the ward and practise his new skills. These "activities of daily living," as they are called, can be taught by special staff or by suitably trained nurses. However, allowing and encouraging the patient to do these things depends on real understanding by the whole nursing staff.

Because of the time required, the special techniques, the equipment needed on the ward and the necessary atmosphere of patient encouragement it is probable that such cases should be treated in special wards of general hospitals or in special hospitals, if they are to benefit maximally. For such wards or hospitals nurses of very high calibre in training, skill and humanity are required. This is not the "old time nursing" but its modern successor in the management of long-term illness.

It is surely important that every nurse be acquainted with the skills and knowledge required in the rehabilitation of those with chronic or long-term conditions. They should know of the excellent results to be expected in many instances. Although the results of treatment are not so rapid or dramatic as in the care of "acute" illness, there is an abiding satisfaction in seeing the handicapped or crippled person regain complete independence and return again to the community and to family living.

Hippocrates noted that "the public believes that those who do not know how to take care of their own bodies are not in a position to think about the care of others."

— *Medical Digest,* 6:5

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The purpose of liberal education is to acquaint students with our common cultural heritage by helping them to integrate the subject matter of related disciplines, and by developing skills, abilities, attitudes and values which enable them to cope more effectively with their personal problems and those of the society in which they live. The essence of liberal education is preparation to live in, work in, and contribute to a democratic society. Beyond this, liberal education contributes to specialization by helping the student perceive the relationship between nursing and other fields of knowledge.

— THERESA I. LYNCH, quoted in *A.J.N.,* 61:5.

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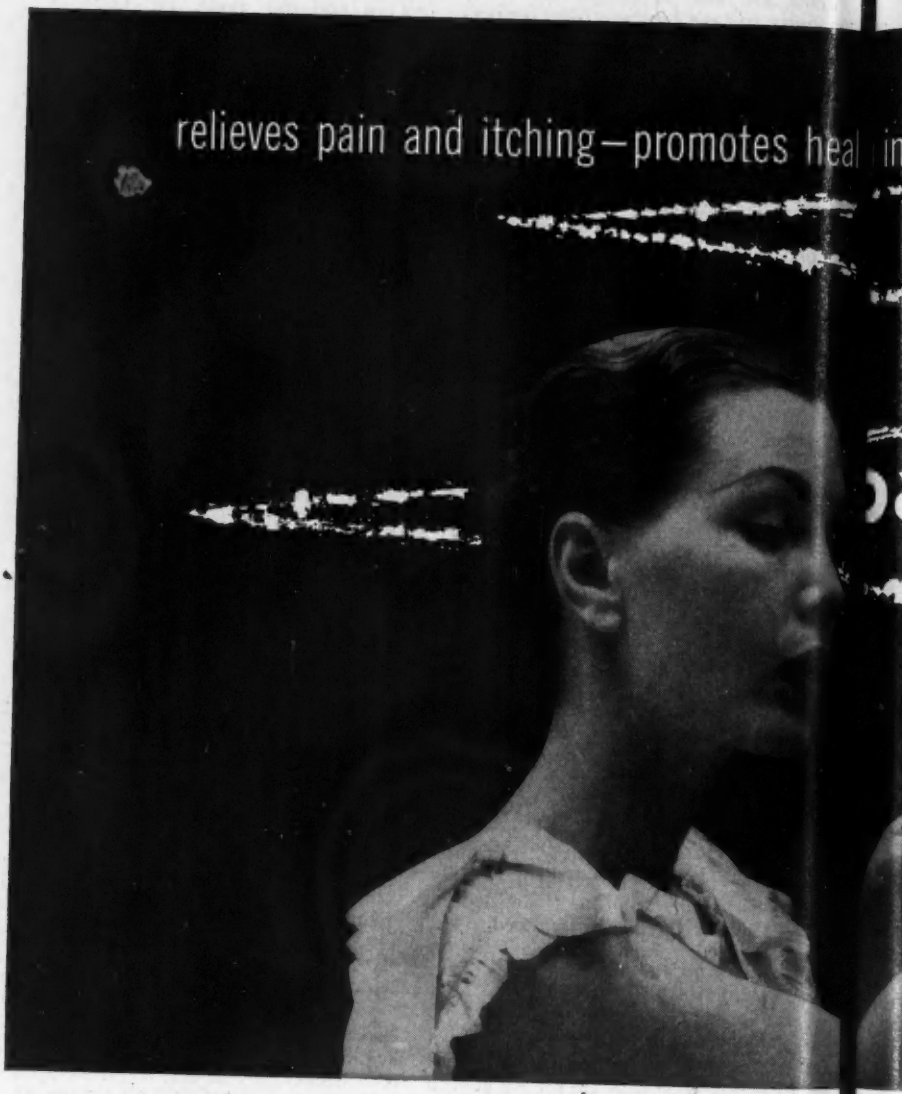
The doctor's daughter went to Sunday School. On returning home father inquired what the lesson had been about. "Dandruff in the Lion's mane," replied the little girl.

— *Ontario Medical Review*



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Tribute to the Pilot Project

Just a year ago, the Report of the Pilot Project for the Evaluation of Schools of Nursing in Canada by HELEN K. MUSSALLEM was published by the CNA under the title *Spotlight on Nursing Education.*

The interest in nursing education across the world is shown by the number of requests for copies of the report, either in French or English, which have come to National Office from schools of nursing in 25 countries. To date more than 2,500 copies have been sold.

International Council of Nurses

Mlle A. CLAMAGERAN of France was elected as the new President with Miss A. OHLSON, USA, 1st Vice-President, Miss T. K. ADRANVALA, India, 2nd Vice-President, Miss G. SCHOTT, Australia, 3rd Vice-President and MISS M. MARRIOTT, U.K., Treasurer, at the Congress in Melbourne. It was decided to hold the 1965 Congress in Frankfurt, Germany.

Controversy at the Congress centred on the interpretation of professional nurse eligibility for membership in ICN. An amendment to the present law proposed that all members should have a general training. An addendum was submitted asking that the question be deferred until the Education Committee has fully investigated the extent of the problem. The amendment was finally carried with a footnote that "after 1965 all nurses qualifying be expected to have had a generalized training." At present countries with specialized trainings can retain full membership.

Among the highlights of the Congress were the following addresses: The Professional Nursing Association —And You! by Miss ALICE GIRARD; The Responsibility of Professional Nurses' Associations for Good Public Relations by Miss MARGARET KERR, Executive Director, *The Canadian Nurse.*

Canadian nurses who will be active on ICN Standing Committees include: HELEN M. CARPENTER, President of the CNA, ICN Committee on Education; ALICE GIRARD, Immediate Past President of the CNA, Chairman, Committee on Nursing Service; LILLIAN PETTIGREW, Executive Secretary and Registrar, MARN, Chairman, Committee on Revision of Constitution and By-laws; MARGARET WHEELER, Division of Industrial Hygiene, Ministry of Health, P.Q., Committee on Public Relations; M. PEARL STIVER, Executive Director of the CNA, Committee on Exchange of Privileges for Nurses.

Notes from CWC Meeting

"Health Care — What do Canadians Need?" was the topic at one of the sessions of the annual meeting of the Canadian Welfare Council held in Ottawa in May, 1961. Dr. K. C. CHARRON, Department of National Health and Welfare brought the group up to date on Canadian progress, in his paper "Where are we now in Health Care in Canada?" This concise and thought-provoking presentation brought many favorable comments from the group.

"Issues and Priorities in Health Care" was the topic presented by Dr. JOHN HASTINGS, School of Hygiene, University of Toronto. In his opening remarks, Dr. Hastings reviewed the changing picture of health in Canada

today and the influences which have brought about these changes. The high complexity of medical science, financing of hospital care, the changing disease picture and the social changes were some of the influences mentioned.

In his discussion of the issues and priorities, he stressed that any program that is to improve health care in Canada must be balanced, and include all public health and preventive services. Many people still live in areas where these services are limited or nonexistent. Therefore, the need for extension of the program to the total population was emphasized.

A program designed to meet the health needs of all the people must provide an even distribution of well qualified personnel. Dr. Hastings urged a closer relationship and a better understanding between all personnel involved. The training of personnel must be built into the program and quality must be the guiding principle.

Dr. Hastings felt that psychology and sociology should permeate the total educational program of the medical students so that they might be prepared to fulfill their obligations to society. He also emphasized the need for medical students to develop high standards of diagnosis, treatment and care of patients. The same broadening of their education applies equally to the other professional groups.

In conclusion, Dr. Hastings stressed the need for better understanding between all professional workers and the general public. He suggested that successful planning implies sitting down and planning together.

Mr. WILLIAM B. BAKER, director, Centre for Community Studies, University of Saskatchewan was guest speaker at the plenary session. His topic, "New Frontiers in Planning," outlined methods by which smaller communities and rural areas can be developed. He expressed the need for an examination of the health and welfare systems in these areas, and the fundamental problems which have to be faced when an urban system expands out into a rural community. He said a community needs to develop its resources and to understand the role of outside agencies in that development. Mr. Baker pointed out that there was usually a proliferation of voluntary associations in a community. He posed the question, "How do they get together to meet the needs of the community?" Mr. Baker asked what methods could be used to coordinate and vitalize the voluntary services in a community. He said that professional people should meet the challenge of working together to develop a better approach in planning their community programs.

When a low-sodium diet fails in a conscientious patient, suspect the water supply and its source. Recent studies, undertaken by two members of the department of biochemistry, Calgary General Hospital, reveal that water from private wells was often so high in tasteless sodium that if a patient on a strict sodium-restricted diet were to drink only two glasses a day, he would unknowingly far exceeds his daily maximum sodium allowance.

Wells drilled in gravel soils, on the other hand, often proved to have low sodium concentrations. Because of land variations, the scientists found it was possible for two farm neighbors to have wells with totally different sodium levels.

— American Heart Association

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For a man to be great, he must have a balance between intelligence and courage.

— NAPOLEON

NURSING PROFILES

One of the exciting moments at the last meeting of the Grand Council at the ICN Congress this year was the announcement of the final results of voting. Members stood and clapped as the new president of the International Council of Nurses, Mademoiselle **Alice Clamageran** of France, made her way to the platform. As president of the National Nurses' Association of her country, she was one of three French delegates in attendance at the congress. Mlle Clamageran attended her first congress in 1933 and has been present at every one held since.

She began her training in 1926 with the Red Cross at a school for nurses in her home city, Rouen. In 1934, she went to England to study at Bedford College, University of London where she enrolled in public health administration under a Florence Nightingale International fellowship. Thus she joined the ranks of the "Old Internationals" and is the first of that group to hold the office of ICN president.

Mlle Clamageran is director of the Rouen General Hospital school of nursing, an institution that trains social workers as well as nurses — a practice that may be unique to France. Her experience in both practical and administrative nursing should equip her well for her new post. She is the second French representative to assume this office, the first being **Léonie Chaptal** who became president in the early 1930's.

(Forde Studio, Kitchener)

REGINA BOROWSKA

Regina Borowska takes up her new duties this month as assistant director of the Extension Course in Nursing Unit Administration, which is sponsored jointly by the Canadian Nurses' Association and the Canadian Hospital Association.

Born in Latvia of Polish parentage, Miss Borowska attended university in Munich, Germany before moving to New Zealand in 1949. Following graduation from the school of nursing of the Middlemore Hospital in Auckland, she became an assistant head nurse there, later engaging in psychiatric nursing until she moved to Canada in 1954. Since then she has worked in general staff, as a head nurse, then as supervisor in the surgical department of the Memorial Hospital in South Waterloo, Ontario. She has completed the course in hospital nursing service administration at the School of Nursing, University of Toronto.

Now a citizen of Canada and fluent in several languages, Miss Borowska will add vigor and enthusiasm to the new program. When time will permit, she hopes to continue her outside interests in reading, music, the theatre and photography.

(C. L. Milne Studios)

M. JEAN DODDS

Margaret Jean Dodds has been appointed director of nursing of the Toronto General Hospital. A graduate of TGH in 1946, she studied nursing education at the Univer-

sity of Western Ontario, London receiving her diploma in 1956. As head nurse and later supervisor in the operating room of her home hospital, she obtained considerable experience in administration and teaching. The past two years as a nursing service supervisor and then as assistant director of nursing service have added to her fund of knowledge.

Miss Dodds replaces Miss **Mary Macfarland** who recently retired from the position after many years of devoted service.

A community birthday party in tribute to a beloved public health nurse had, as its guest of honor, **Muriel Rice** who is on the staff of the Temiskaming Health Unit in Ontario.

Miss Rice began her career in nursing as a student at the Lady Minto Hospital, Haileybury, later transferring to the Kingston General Hospital from which she graduated in 1922. After three years of private nursing, she entered the public health field first on the staff of the Dome Mine and later under the auspices of the Red Cross Society, at Ontario health units in Englehart, Blind River and Manitoulin Island. This was followed by a period as health nurse on Manitoulin Island, in Lion's Head and Port Credit, Ont., before she moved on to Kirkland Lake. A period of postgraduate study in public health nursing at the University of Western Ontario was followed by her return to Kirkland Lake and her first association with the Victorian Order of Nurses.

MURIEL RICE

As a VON member, Miss Rice worked in Yarmouth, N.S. and North Bay, Ont. In 1950 she became public health nurse in Haileybury and, in the following year, joined the Temiskaming Health Unit. The gifts, the good wishes and other tributes of district residents indicated the general appreciation felt for this hard-working member of the nursing profession.

Danger and Safeguard

Whatever our personal attitude may be, we must face the fact that mass organization of medical care is the logical and inevitable result of modern social development, and by definition it is the public health system that realizes this mass organization.

But let us not forget that in itself any organization, and certainly one of a scale as seems necessary here, tends to reduce human individuality to a cypher.

It would be foolish to try to curb the technical development in itself; the laborers who destroyed the first steam-driven factories did not strike their real enemy. Technical development is only rendered significant by the spirit of the humans that handle it. Mass measures inspired by technological development or by mass demands for security become dangerous as soon as they require mass behavior for their success.

In other words, if a docile and uniform population is a necessary condition for the success of a measure, this measure is a danger to the mental health of the population. In that case the ends and the means have changed places, the provisions are no longer for the people, but the people are there to justify the organization.

It is, therefore, clearly the task of public health to reconcile its duties towards society with those towards the individual, and in order to do this the very first principle of mental health must be constantly borne in mind by those who practice it. This principle is extremely simple; it is the genuine interest in the human being as such, for this is what the practical application of mental health principles amounts to.

Prof. A. Querido, Professor
of Social Medicine, Amsterdam

Preparing the Third-year Student for Responsibility

LINDA LONG

Is the student nurse's third year necessary in preparation for future responsibility?

THE FOREGOING is a very controversial question in many schools of nursing who are so aware of the two-year educational program for student nurses that seems to be becoming increasingly popular in Canada and the United States. In order to give an answer to this question, others seem necessary. What preparation for responsibility is given in the planned curriculum of the two-year program? What responsibilities are expected of the graduate nurse after completion of such a program? What are the responsibilities expected of *any* graduate nurse?

A definition of the role of the graduate nurse is greatly needed but it is a tremendous topic for study and carries with it many controversial views about her present function. It is not my purpose to define what is expected of the graduate nurse in the various positions of responsibility that she assumes. It seems sufficient to say that there are certain functions that she is expected to perform that are common to the varied fields of nursing. Then we should ask ourselves what we are doing to prepare her to perform these functions and accept her responsibilities and what else we can do in our present situation to improve her preparation.

In order to answer this question let us look at one school of nursing to see what *is* being done and what *could* be done to further prepare the graduate nurse for responsibility. In this way, some may receive new ideas, but it will also reveal the problems awaiting an answer.

Expectations

What are some of the common expectations or functions of the graduate nurse?

1. The technical function of nursing procedures.
2. She acts as an administrator in ordering supplies and keeping records.
3. She is an organizer, who must work in and maintain a complex organization replete with problems of hierarchy, communication, and control. She is supervised, and she supervises.
4. She is a teacher and trainer of other hospital personnel and of patients.
5. She involves herself in the informal social fabric of the hospital, clinic, or agency, interacting with colleagues with whom she shares intimacies, small talk, gossip and social intercourse.

Conflicts

Knowing this, where then are the problems or conflicts that seem to exist in her role?

1. The nurse is commonly frustrated by the difference between her image of *real* nursing and the functions she must assume in actual work situations. The girl entering a school of nursing who has bedside care of the patient as her image of nursing receives a severe jolt. She is not prepared, psychologically or technically, for the myriad of other duties that she has to perform. She is not really sure she likes it that way. In the many interviews held with student applicants, their reason for choosing nursing seems to be the ideal image that puts bedside care of the patient at the heart of the legitimate functions of nursing. In other words, bedside care to them is *real* nursing. Added to this is the non-nursing public's image of the nurse always at the bedside of the patient. Doctors, too, frequently judge nurses in terms of a similar image.
2. The nurse-doctor relationship is often another tension area. Many doctors seem to disapprove of any move in nursing toward more professionalism or, if aware of it, ignore it. An earmark of a professional person is the possession

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Miss Long, assistant director of education, Saskatoon City Hospital, presented this paper at the Saskatchewan provincial instructors institute held in Prince Albert, April, 1960.

of areas for exercise of independent judgment within her work life. Many doctors still expect nurses to behave only as obedient extensions of their own professional judgment. The fiction seems to be that the nurse is the doctor's helper only. Yet, in fact, nurses must frequently make independent judgments that affect the treatment process.

3. Promotion for the nurse all too frequently means conflict between her desire for higher status and her psychological need to give bedside care. If a graduate nurse really wants to advance within the hospital setting, she will have to take on more and more administrative functions. In doing so she may feel painfully unprepared for the responsibility. Also, she does not think of it as real nursing.

The healthiest way in which we can handle these conflicts is, first of all, to accept the fact that they exist. Then we must locate the sources and do something about them.

Philosophy

Each school of nursing must have some basic philosophy that serves to guide it in the establishment of a program for student nurses. This philosophy must be realistic, practical and *continually used* by all members of the faculty in the school. If not used, it becomes a star beyond our reach, beautiful but serving no other purpose. This philosophy must be accepted by the hospital board of administration. There should be an appreciation of the responsibility that a school of nursing owes to a student. This is easier said than done, but it should not prevent us from trying still harder to make it more of a reality.

Since nursing is a profession, the school of nursing must always keep in mind the responsibility that it assumes when accepting students and present them with a course of studies and experiences that are conducive to producing a professional person.

Because the student utilizes and depends upon the facilities of the hospital for her learning experiences, she is expected to reimburse the hospital by giving a certain amount of service. This should not be permitted to interfere with her educational program. The program should provide opportunities for experience in problem solving; for the development and use of initiative and resourcefulness; for development of the ability to understand people and of those spiritual qualities that make for personal and professional satisfaction.

Aims

1. To give the nursing student sufficient knowledge for the accomplishment of intelligent nursing care by providing:

   a) A fundamental background of scientific knowledge that will stimulate interest in further growth and development;

   b) supervised clinical situations in which the student can use and add to her knowledge;

   c) opportunities for the appreciation of and practice in health teaching within the hospital and community;

   d) opportunities for advanced experience in particular fields of interest and ability.

2. To develop nursing skills in the student through:

   a) An understanding of basic principles (scientific, sociological, psychological) necessary for comprehensive nursing care;

   b) development and maintenance of mental and motor skills in performing procedures;

   c) development and maintenance of the ability to adjust to new and challenging situations.

3. To provide for professional, personal and social growth through example, guidance and encouragement in extra-curricular activities, so that the nurse:

   a) May work effectively in varied clinical situations;

   b) may develop all the potentialities that make for a well-balanced person and an efficient nurse thus assuring satisfaction in both her personal and professional life. This will assist her to assume her role in the community through active participation in: Mental health activities; promotion of community health activities and resources; interpretation to the public of trends in the nursing profession.

The philosophy and aims of the school are achieved by the faculty pooling their ideas and determining what can be achieved in specific areas.

This serves as a guide to establish what can be done in the total school program.

Student Selection

The selection of students is very important. Consideration must be given to scholastic ability, health and personal qualities. Age is a controversial point. The provincial minimum in Saskatchewan is 17 years and it is disputable as to whether, at that age, a student is ready for the responsibilities that she must meet in everyday situations on the ward. How ready is she to exercise good judgment, self-control and self-confidence in the responsibilities delegated to her? Are we not expecting too much of her?

The Curriculum

In the Saskatoon City Hospital, the following pattern is used.

Basic Preliminary Course

(32 weeks)

a) Centralized Teaching Program (16 weeks): Students from nearly all schools in the province attend these classes. The basic sciences, social and biological, are taught at this time. The most important advantages of this program would seem to be:

1. A concentrated block of classes in which the student can devote her efforts to learning, without the frustration of ward situations;
2. lectures given by well-qualified teachers.

Preliminary Junior Classes

(16 weeks)

An integrated block of classes in medicine, surgery, diet therapy, pharmacology, pathology, fundamentals of nursing and some periods of planned practice on the wards.

Junior — Intermediate — Senior Classes

Following the preliminary program, the junior students receive full-time clinical experience in medicine and surgery for a minimum of 8-12 consecutive weeks in each. There are several advantages in such consecutive experience:

a) A planned program of teaching can be established for the student;

b) student has more time to learn in the situation and thus a greater appreciation and understanding of the subject;

c) nursing service needs are better satisfied as orientation of new staff is minimal;

d) a planned rotation of experience for the student is possible.

Junior students are not given the responsibility of evening and night duty until they have had sufficient opportunity to learn under day supervision. The decision as to the student's readiness is made by the clinical instructor and the head nurse or her assistant. This assures better work performance and a more satisfied nursing service. The amount of evening and night experience for the student should be limited. She needs the benefit of the more extensive clinical teaching program and supervision carried out during the day.

During the first year the rotation to clinical areas includes the operating room, recovery room, central supply room, diet kitchen. Students are posted in groups to each of the above areas, so that a planned program of teaching and experience is possible. Concurrent teaching is practised in all clinical fields excepting that of the diet kitchen.

The second-year student is occupied with clinical experience in the special areas of obstetrics, pediatrics, tuberculosis and psychiatry. The junior and senior students are available for general medicine and surgery.

The presence of the junior student in these fields has previously been qualified. She is receiving experience in the two basic subjects that provide the foundation for future knowledge. What excuse can be found for the third-year student? Many answers could be ventured but we must look very objectively at what is planned for her to justify her presence.

The modern student is encouraged to ask more questions. This is a learning process. Student applicants are becoming more analytical about what a school has to offer. There are many more fields of learning open to women and these opportunities will be compared to those offered in a school of nursing program. The senior student is discontented if extra responsibility is not given to her and her performance suffers.

An additional problem for students is the place of the nursing assistant in relation to the graduate nurse. This is of concern to many because the use

of auxiliary nurses has mushroomed before we had defined exactly the role of the graduate nurse and of the nursing assistant.

The third-year student receives the following clinical experience:

Emergency Department (4 weeks): After her background of experience in the various clinical areas, she is more prepared to meet with emergency situations. She assumes complete responsibility in the evening. An individual teaching program is established for her on the basis of her past experience.

Senior Charge Experience (8-10 weeks): This is either in medicine or surgery, and if possible, in both. The program is carefully planned with internal rotation of experience under the supervision of clinical instructors and head nurses.

The students receive classes in ward management, professional adjustments, emergency nursing, community health problems. It is hoped that more senior aspects of medicine and surgery will be included in the future.

Senior Experience (elective) in medicine, surgery, operating room, pediatrics: Experiences are planned in some of these areas, but much more needs to be done in order that it be a more valuable experience.

Classes in Senior Year (3-4 weeks complete block): These classes are given in a block, prior to clinical experience. This at present seems most suitable to the rotation master plan, but the advantages of spreading the classes over a longer period are under consideration. This will be easier once psychiatric affiliation has been established for all students in the province.

Now let us look at some of the expectations for the third year as expressed by instructors or senior students themselves.

The Instructor's Viewpoint

A clinical instructor in surgery expresses her expectations for the third-year student as follows:

1. Showing an interest in and ability to accept responsibility.
   a) She should know her limitations and not accept responsibility of which she is not capable.
   b) She should seek responsibility, realizing that there is often someone who could do things easier in areas where she would like to gain experience.
   c) She should know to whom she is responsible for each assignment that she accepts and where she can obtain guidance as required.
2. Developing and maintaining a sustained basic curiosity about nursing so that she will continue to grow, mature and broaden her interest in nursing.
3. Developing the ability to assess the patient's condition or needs and to determine the action to be taken.
4. Developing an awareness of the importance of a pleasant, professional rapport with patients and staff members.

The Student's Viewpoint

A third-year student just beginning her senior experience wanted opportunities in various areas.

A. To assume responsibility:
   1. Experience in making decisions (insight and judgment);
   2. opportunity to direct and guide junior students and nursing assistants (team leader);
   3. experience in supervising a unit or part of a unit;
   4. experience in assisting the head nurse thus becoming more aware of her function and responsibility.

B. To develop a better awareness of patients' needs and the ability to meet them.

C. To acquire a better understanding of diagnostic tests. Relate laboratory values and other reports to the patient's specific condition.

D. To see the place of the hospital in the community in relation to other community resources.

E. To develop good interpersonal relationships:
   1. At ward level, for example, ward aides, head nurses, doctors;
   2. with departments, for example, laboratory, x-ray, diet kitchen;
   3. in the community, for example, clergy, social workers.

F. To carry out health teaching:
   1. For patients
   2. for parents of children
   3. for relatives

G. To develop and maintain a greater curiosity about nursing.

H. To gain more self-confidence and assurance.

Did the student who had had planned senior experience feel that it met objectives? Yes, in many ways but many

would be realized only as experience progressed. The third year should be and could be an excellent learning experience for the senior student. Whether it was or not depended upon many factors.

1. The main one was the interest and initiative of the student herself.

2. The past experience that the student had had should enable her to know what she still needed to learn.

3. The opportunities available to meet the objectives would depend upon the student's previous learning.

How could the senior term have been more beneficial?

1. By providing more experience as a team leader over a longer period of time since this

a. forms the groundwork for other areas;
b. offers practice in evaluation of situations;
c. results in greater knowledge of patients' conditions;
d. promotes a closer contact with the head nurse.

2. By providing more opportunity for senior responsibility on night duty and evening shift.

3. By providing more community experience in public health aspects.

Teaching Problems

The clinical instructor met certain difficulties in dealing with the senior student. The third-year student, for example, comes to the ward after an absence from general surgery of over a year. She often displays a pseudo-confidence since she is now a senior and realizes she should act the part. She frequently has forgotten many details about procedures and surgical conditions.

To replace this pseudo-confidence with a true confidence:

a. A guided program is necessary;

b. the student should be encouraged to review procedures, conditions and drugs before coming and while on the ward;

c. she should participate actively to some extent in clinical and health teaching for example, organizing ward clinics or supervising junior students in health teaching.

A second problem is the difficulty in arranging evening experience. A large ward may have two graduates on evening duty. This means that the student would have a graduate nurse working as her junior. Finally a large percentage of the instructor's time is spent with the junior student, either in class or on the ward, leaving less time to spend with the senior student.

The requests by the senior students for more community health experience is certainly being considered. However, facilities in this particular community are not adequate to meet the demands at the present time. Where it is possible to obtain visits to community agencies within the city, this has been done.

One aspect of the curriculum that should not be forgotten is the social program, with time and opportunity for social and personal development. This should be strongly supported by all nurse educators in order that a student may become a more interesting, self-directing individual.

Conclusion

We have much more to do towards planning the student's third year in this school. We are more conscious now of what is needed to fulfill the student's expectations and of the responsibilities required of her as a graduate nurse. The third year, to us, is a very essential and critical year, just as the first year is. The first year serves as a firm *foundation* for the second year, so it must be planned with care. The third year is a *protective* one, during which supervision in assuming responsibility is constantly supplied. As a result, after graduation the nurse is enabled to adjust more readily to the variations of responsibility imposed upon her.

Junk: Something you keep for 10 years and throw away two weeks before you need it. — *English Digest*

* * *

The doctor's wife was unsuccessfully trying to persuade her 14-year-old daughter that she was too young to wear a strapless gown to a school dance. As a compromise they both agreed to abide by father's opinion. The doctor solved it with this anatomical answer. "If it will stay up, she is old enough to wear it." — *Ontario Medical Review*

APPLIED SOCIOLOGY for Nurses

CYRIL GREENLAND

The study of sociology helps to increase the nurse's understanding of people.

IN THE PAST DECADE progress in the field of psychiatry has made considerable demands on the resources of all the helping professions. Problems of recruitment, training and leadership have in consequence taken on an urgent note. Duties and responsibilities, previously assumed to be well defined and settled, have undergone rapid change. For example, the widely accepted concept of the "therapeutic team," in practice results in breaking down many of the traditional roles of the doctor, nurse and social worker. Indeed, there is often considerable and, not infrequently, a confusing degree of overlapping and interchange of function. Lurking behind the team approach are formidable dangers to professional development. However, although this is open to argument, few will deny that inter-professional collaboration results in larger and ever-expanding areas of common interest and mutual concern.

In part at least, these areas of concern are due to the changing concepts of sickness and health which, in recent years, have gained wide currency. Disease is no longer seen as just the invasion of the body by pathogens but as an individual's morbid response to a wide spectrum of stresses. Health is regarded not merely as an absence of symptoms but as a state of optimum well-being in all areas of living. Since symptomatic recovery is no longer the main objective of treatment, the patient's function in relation to his family, friends, work and play is of interest to the doctor and the nurse as well as to the social worker. To be effective, treatment by each member of the team must be related to the patient's way of life. Thus, nurses and doctors must enlarge their present field of competence and understanding to include social science and applied sociology.

Mr. Greenland is social work advisor with the mental health branch of the Ontario Department of Health.

This is not an entirely new departure in medicine, nursing or psychiatry. For some years now a number of hospital schools have included sociology, or aspects of it, in their curricula. With some exceptions, however, the material tended to be weighted heavily towards what might be called social psychopathology. While students were adequately informed about the abnormal processes, they seldom had the same opportunity to study the healthy development, growth and behavior of essentially normal individuals and their families. It should also be said that, in the past, student social workers tended to make unduly elaborate excursions into the underworld of psychopathology. Recently they have made a welcome return to the pastoral scene.

The health professions have given so much attention to sickness in all its aspects that it has become increasingly difficult to find reliable guide lines to what is normal in human relations. Consequently, there is a danger of regarding conduct as abnormal because it does not conform to a predetermined pattern, usually that which the professional person regards as acceptable. Variations in attitudes due to social class, culture, religion or racial origin may be regarded erroneously as eccentric or even morbid. In Canada, with its diversity of racial groups, the absence of knowledge about other ways of life can easily result in serious errors in judgment. We must be careful not to impose or expect patterns of behavior that may be alien.

This kind of information, much of which is now united under the general title of social psychiatry, was conveyed in sporadic lectures to several generations of student nurses in this hospital. Two years ago at the suggestion of Miss Dorothy G. Riddell, senior inspector of schools of nursing in Ontario and at the invitation of the director of the school of nursing, the writer was asked to outline and present a course of lectures on sociology for

nurses. Formal teaching was to be reinforced by periods of observation and an opportunity for personal experience in a social work department. The aim was not to create a "centaur," in this case an elegant hybrid of half social worker, half nurse. On the contrary, it was hoped that the broadened educational opportunity would enable the students to preserve their identity as nurses and grow in competence. It was recognized that to be really effective, sociology would have to be well integrated into all other areas of learning. In consultation with the teaching staff. the following syllabus was devised:

Sociology of Social Problems
Outline of Lecture Discussions
for Student Nurses
The Ontario Hospital, Whitby

1. *The family in society*

Six lecture discussions on the organization of the family; the roles and responsibilities of parents and children; variations in child-rearing patterns and family relationships in different classes and cultures.

2. *Common human needs*

Twelve lecture discussions on the normal stresses of life found in infancy, childhood, adolescence, employment, courtship and marriage, parenthood, housekeeping, leisure and old age.

3. *The individual in the community*

Six lecture discussions on the history and growth of social services, provision for health and welfare; the role of voluntary organizations.

4. *Social problems*

Twelve lecture discussions on crime and delinquency, alcoholism, addiction, prostitution, illegitimacy, suicide, problem families, gambling, etc.

5. *Positive mental health*

Six lecture discussions on concepts of mental health in the individual, the home, school, industry and community; special problems of immigrants and racial minorities.

6. *Social aspects of psychiatry*

Six lecture discussions on the social history of psychiatry, lunacy legislation, methods of admission to and discharge from hospital; epidemiology of mental illness; mental health services, rehabilitation, principles and practices of social work and the role of social workers in the mental hospitals.

It will be seen that the first half of the syllabus is concerned with teaching normal growth and development. The second half, dealing with major social problems, provides a broader foundation for the teaching of psychiatry that follows. In this way, students are prepared to examine in a meaningful way, the history and growth of social services and provisions for health and welfare. This helps to avoid the possibility that these lectures will be reduced to a set of unrelated facts, to be recalled only for purposes of examinations. Another reason for presenting the material in this order is that students are able to relate what is being taught to their own personal experience and observations of life around them. This was of decisive importance at Whitby, where the majority of students had only just completed high school. The opportunity to identify themselves in a personal way with what was being taught was significant.

The class of 19 members was made up of two groups — 13 junior students who had not been on the wards at that stage, and six senior students. The difficulties of mixing the two groups were discussed at length and, although catastrophe was predicted, it was decided to go ahead. Since this was a new course it was agreed that the lectures would be monitored by at least two of the three instructors. At the outset both the lecturer and some of the students were rather apprehensive about such an arrangement. Later, as the course progressed, the monitors became accepted as participating members of the group.

Method

In a course of this kind, participation — learning by doing — is essential. Consequently the organization of each session — seating arrangements, lecture content, presentation and discussion method — was planned in advance. Students were seated in a full circle that was completed by the lecturer at his desk. Immediately behind him was a blackboard upon which relevant data were written in advance.

At the first session a class chairman and secretary were elected. In addition to her formal function the chairman, a senior student, was responsible for collecting topical material, press clippings, etc., and for the equitable dis-

tribution of assignments. The class secretary a preliminary student, took minutes and reported back at the beginning of each session. Keeping a record of this kind has a number of advantages in addition to giving a student useful experience. It enables the teacher to estimate what is being absorbed and to correct distorted impressions. Continuity is preserved by the recapitulation of principles. Finally, and this is important, a record of progress in the development of the course is available to both the students and instructors. Ideally, the position of class secretary should be shared so that the burden does not rest entirely upon one person for the whole course. The Whitby students, however, elected not to do this and their wishes were respected.

Teaching aids

A variety of teaching aids was used. The most valuable were those provided by the students. They were encouraged to bring press clippings and magazine articles to each session. These were used to illustrate a particular point or even to support an argument, often contrary to the one expressed by the lecturer. Television and radio programs frequently provided stimulating discussion material.

Student assignments included readings from plays that pinpointed particular problems under discussion. For example *Four-poster* was used effectively to illustrate certain problems of marital adjustment; *A Hatful of Rain* demonstrated the family problems of the drug addict. On the other hand, although it was available, Arthur Miller's play, *Death of a Salesman* was not used. It was felt that the emotional problems with which the play deals were not relevant to the needs of this particular group of students.

To give them a more intimate understanding of problems such as those of recent immigrants, married women at work and under-privileged families, students were assigned interviews that they later reported to the class.

Every fourth session was devoted to a film at which a member of the class was designated as discussion leader. A particular problem was to find a suitable film that was available at the appropriate time. On the whole, my impression was that, however good, a film shown out of sequence with the class program was wasteful. It also had a disturbing effect on the junior students who found it difficult to relate the film's content to their previous discussions. This emphasizes the need for an orderly progression of ideas and supporting materials that are delicately geared to the needs of preliminary students. In a more sophisticated and experienced group it is unlikely that this would be of such importance.

Rag-bag sessions

Once the students found themselves free to discuss and encouraged to argue, it became difficult to keep to the agreed schedule. Discussions that had to be postponed because of lack of time or because what was being said was not strictly relevant made the students feel cheated. Occasionally, there was a sullen withdrawal of interest among the group. As a not entirely successful means of overcoming this, "rag-bag sessions" were introduced. "Hot" subjects were saved up until there was sufficient material to devote a whole period to discussing them. It should have been anticipated that, with the passage of time, the intensity of feeling about a topic would decline to a considerable extent. This, in itself, was a useful experience for us all.

Assignments of practical work

As already indicated, work assignments were regarded as an important part of the course. For the junior students, relatively small assignments were required. These consisted mainly of interviewing for the purpose of gathering information about existing services such as those available to expectant mothers in the immediate area. One student reported on an interview with the Victorian Order of Nurses' supervisor. Another student investigated the financial cost of having a baby. At the same session a senior student reported on the feelings and attitudes of expectant parents, and the discussion concluded with a debate on the problems of working mothers.

The senior students spent a full month in the Social Service Department. During this time they visited agencies such as the Children's Aid Society, the National Employment

Service, the local public health and welfare department and the Juvenile and Family Court. They also spent a full day in an automobile factory and evenings at a community recreation centre, the YMCA, and Senior Citizens' Club. The seniors had a major research assignment.

Conclusion

As a starting point in the study of human relationships we must accept that what we think and what we believe profoundly affects our understanding of facts. The reverse is also true. New facts may conflict with our most cherished beliefs at first. In teaching young nurses who, for the first time in their lives may be away from home, these feelings must be handled with considerable delicacy. On the other hand, if the nurse, as a professional person, is required to be sensitively aware that her personal standards may not be shared by her colleagues, teachers or patients, she must determine what her standards are and how she came to acquire them. The teacher is under an ethical obligation not to undermine those beliefs that are fundamental to the young student's personality and may be the cement that binds her to her family and culture.

Maturation, however, is a process during which personal standards are critically examined, tested and often exchanged in favor of enduring adult values. With young people this can be a period of considerable turbulence. Those responsible for the selection and training of student nurses may find it necessary to reconsider their decision if the student fails to demonstrate a capacity for growth. In other words, it is suggested that a course in sociology that involves the participation of the students as individuals may expose personal problems which less personal procedures might obscure. It is suggested that, since the practice of psychiatric nursing requires considerable skill in inter-personal relationships, particular attention should be paid to those areas of learning in which cherished beliefs and feelings may be threatened.

The lecture course outline here is only one small part of a new approach to the education of nurses at this hospital. It is too soon to say what the ultimate result will be. There are some indications that, in relation to patients, the junior students were quickly able to apply some of the concepts of human growth and development. No similar observation was made by the nursing instructor about the senior students who took the same course. It is, however, only fair to say that they were at the end of their training and somewhat preoccupied with the need to successfully complete their final examinations.

The author acknowledges the kindness of Dr. D. O. Lynch, superintendent, for permission to publish this paper; of Miss Helen Whitman, director of nurses, and of the nursing instructors at Whitby for their interest and friendly cooperation.

No nurse can be developed through outside influences; she must develop herself. The association (ANA) can furnish knowledge and guidance; it can point out some of the best courses of action; and sometimes, it can provide inspiration. But what the nurse actually *gets* depends on her own wish and will to learn.

— Elizabeth K. Porter,
quoted in *A.J.N.*, 61:5

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Dr. Benjamin Spock, noted pediatrician, has contributed to the Parent Series of pamphlets published by the National Society for Crippled Children and Adults.

In "On Being a Parent — of a Handicappel Child" Dr. Spock emphasizes that crippled children range all up and down the scale of human behavior — just like children without handicaps.

The way parents view their child is primarily the only way he can acquire his sense of himself. "Whether they consider him weak or husky, attractive or unappealing, good or bad, pathetic or terrific, he will tend — other things being equal — to accept their view," says Dr. Spock.

Copies, which are 25 cents each, can be obtained only through the Publications Service, National Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago 12, Illinois.

In Memoriam

Miriam O. Allen, a graduate of Victoria Public Hospital, Fredericton in 1934, died May 12, 1961. She was a staff member of the Victorian Order of Nurses for several years and an instructor with the local branch of the St. John Ambulance Brigade.

* * *

Marianne Shirley (Seed) Bohne who graduated from the Vancouver General Hospital in 1955, died recently.

* * *

Gertrude Sweeney Fergusson, a graduate of Yarmouth Hospital, N.S., died in April 1961 after a lengthy illness. She had been associated with Queen's General Hospital, Liverpool, N.S. since 1949.

* * *

Vivian (Treanor) Gifford who graduated from St. Paul's Hospital, Vancouver in 1935 died during the early months of 1961.

* * *

Mildred R. (Christianson) Hawkins, a 1933 graduate of Vancouver General Hospital, died early in 1961.

* * *

Lucy Dorothy Heaslip who graduated from Buchanan Hospital, St. Leonards-on-Sea, Sussex, England in 1950 in Toronto on April 26, 1961.

* * *

Mary Jane (Young) Hughes who graduated from Regina General Hospital, Sask. in 1921, died in Dawson Creek, B.C. on April 11, 1961.

* * *

Mary Jones, a graduate of Victoria Hospital, London, Ont. in 1927 died on May 14, 1961. She had engaged in private nursing from the time of her graduation.

* * *

Mary Louise (Moffatt) King who graduated from Wellesley Division, Toronto General Hospital in 1958, died in Toronto on May 23, 1961.

* * *

Mary Madeline (Krohe) Kramer, a 1921 graduate of St. Mary's Hospital, Detroit, died in Delhi, Ont. on May 31, 1960.

* * *

Sister Mary Christine (Penny McIntosh) who graduated from St. Mary's Hospital, Montreal in 1949, died in Toronto on May 18, 1961.

Cecile (Martin) Lajoie who graduated from St. Vincent de Paul Hospital, Sherbrooke, P.Q., died on May 4, 1961. She had engaged in private nursing in St. Hyacinthe, P.Q. for the past eight years.

* * *

Madeleine (Huck) Lane who graduated from Toronto Western Hospital in 1909, died on March 11, 1961.

* * *

Georgina (Paton) MacPherson, a Canadian graduate of Boston Homoeopathic Hospital, Massachusetts in 1892, died in Halifax on April 13, 1961. After working in Halifax for a few years, she accepted a position as matron of Grenfell Medical Mission Hospital, Battle Harbour, Labrador. Following her marriage, she and her husband, a doctor, operated a hospital in Salina Cruz, Mexico for 25 years. Mrs. MacPherson was 96 years of age.

* * *

Sister Mary Noemi, a 1921 graduate of St. Joseph's Hospital, Victoria, B.C. died in Lachine, P.Q. on March 13, 1961. She had been active in nursing until a few months before her death and for many years, was supervisor of the obstetrical department at St. Joseph's Hospital. She also developed and organized the Central Service and Supply Dept. of the same hospital.

* * *

Mary Farmer Steel who graduated from the Royal Victoria Hospital, Montreal in 1902 died in Vancouver on May 28, 1961. During World War I she served overseas with the First Canadian McGill Unit of Nurses. She was awarded the Royal Red Cross in recognition of her services, 1914-19.

* * *

Leonore Elizabeth Anna Martha (Werner) Wulferding, who graduated from a hospital in Berlin, Germany in 1948 and later studied at the Greater Niagara General Hospital, Niagara Falls, died in Toronto this year.

* * *

Anna T. Young, a graduate of Victoria General Hospital Halifax, died in March, 1961. She had served in France during World War I and later was on the staff of Camp Hill Hospital, Halifax before engaging in private nursing.

Character is not made in a crisis — it is only exhibited. — ROBERT FREEMAN

NURSE-SCOPE

PATRICIA S. B. ANDERSON, B.S.N.

A method of in-service education.

"Here it is Fall again. So many graduates to orient, so little time to help them!"

"Yes, I've had a new graduate in my department every week this month and everyone with such varied experience."

"Same with me. We have had nurses from Australia, England, Bermuda and South Africa as well as Canadian girls who have had their basic course in all sizes of units."

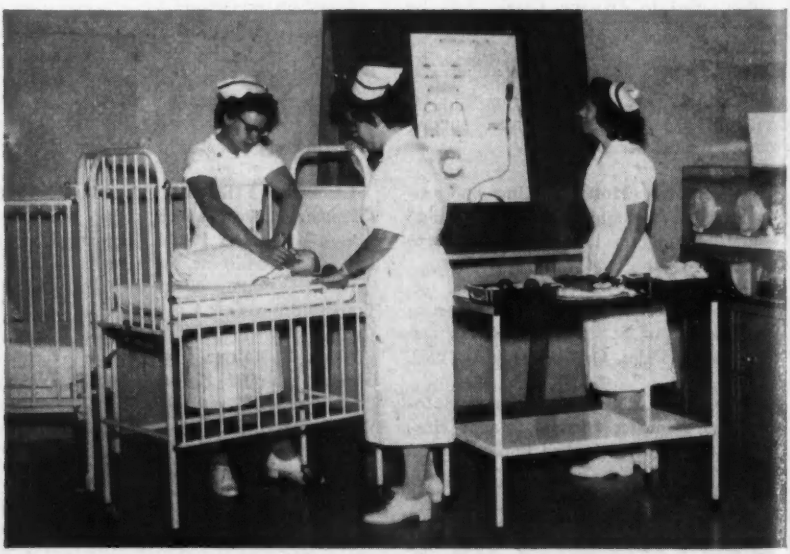
"On top of this we have to keep our own new graduates interested."

Yes, everyone involved in orientation brought this problem to the in-service education committee*. *How can we orient quickly and in an interesting manner, general duty graduates who have had a variety of experiences in pediatric nursing?* "Nurse-scope" was created to help solve this problem.

What was "Nurse-scope?" It was a series of displays illustrating certain methods used in caring for the child in this hospital. During the initial planning the general duty group started to take the initiative. Soon, it was their show. The coordinators, head nurses and clinical instructors faded into the background as consultants. The hospital hummed with creative activity. Paints, brushes, scissors, cameras and dolls all got into the act.

For three successive weeks there was a series of displays from the various nursing units in our big conference room. The general duty nurses gave brief commentaries on each nursing care situation. The profusion of questions indicated the keen interest of the newcomers. Other departments participated. A great deal of interest centred around the inhalation therapy demonstration. Here, the inhalation therapist demonstrated familiar as well as new pieces of equipment. The "whole" child was not neglected. Safe, suitable toys kept the doll babies happy. The child development and occupational therapy departments showed their role in total care.

Miss Anderson is Supervisor of in-service education for the graduate staff, Hospital for Sick Children, Toronto.



"Nurse-scope" in action

Soon other benefits became apparent. Nurses riding the elevators greeted each other with friendliness. Yes, they had met at "Nurse-scope." The general duty nurses were able to use supervision in a more positive way. They had learned that a coordinator *works with* the staff member to attain a common goal. When visitors from outside the hospital arrived, the nurses had the opportunity to act as hostesses in a professional situation. Previously unknown talents appeared. One nurse created eye-catching posters; another showed special organizing ability, and a third displayed unexpected teaching skill. "Nurse-scope" was beneficial in many areas.

Soon the nursing community in the metropolitan area heard of our project. The Committee invited staff members from all hospitals and public health nursing agencies in the geographic area to attend. The large turnout was evidence of their enthusiasm and interest. Again, a variety of results was reaped. Nurses from small pediatric units reviewed new and established ways of carrying out certain nursing measures for the little patients. Nurses from in-service education programs saw a demonstration of a new method of education for graduate nurses. Public health nurses were kept up-to-date with some of the current pediatric nursing practices. Visiting nurses saw procedures that may be carried out for patients after discharge. The enthusiasm and generally friendly atmosphere improved relationships between the nurse in the hospital and the one in the community.

Did "Nurse-scope" achieve its primary objective? No attempt was made to evaluate the project formally. We had to depend on the old-fashioned grape-vine technique.

"Did you know why we were to give intramusculars into the thigh?"

"I always thought the "Play Ladies" just kept the kids out of mischief. They are actually part of the therapy."

"That is a neat stand for closed drainage. I wonder where our department can get one."

"Did you see that new vaporizer? It will be a great help."

"Nurse-scope" appeared to be an efficient method in helping graduate nurses familiarize themselves with certain methods of caring for the sick child.

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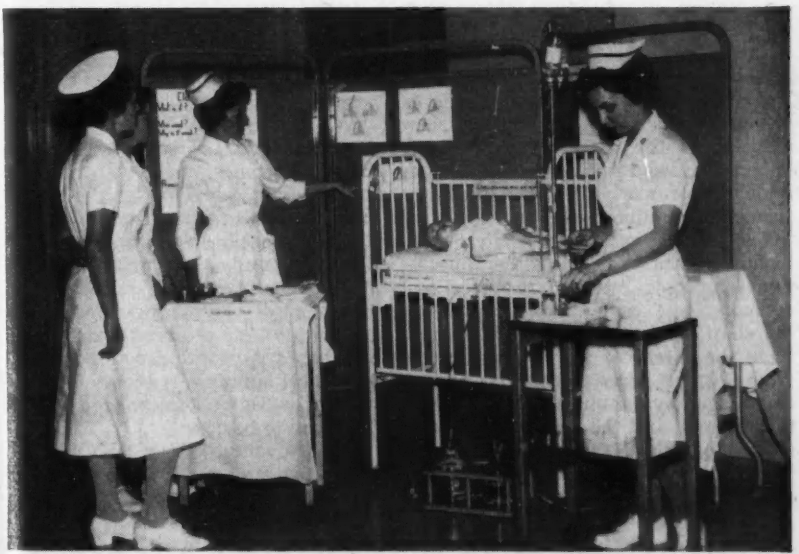
*The in-service committee was composed of staff members from the administrative group and representatives of the general duty graduates. The function of this committee was to set up over-all policies for the in-service education program and plan the programs.



A great deal of interest shown

THE STORKS FLY ON

MARGARET M. MADDEN, B.A., M.T.D.

The Advanced Practical Obstetrics Course at the School of Nursing, University of Alberta began during the fall of 1943. In 1944 and 1945 articles about it appeared in The Canadian Nurse. Except for modest advertisements in the Journal, nothing has been written about this unique course since that time. This article will help to fill in the gap.

BY 1916, there were 10 or 12 district nurses working in the rural areas of Alberta. This service had been made necessary by the migration of great numbers of people (estimated at one million) into the Canadian West during the opening years of the century. The population of Alberta increased over 400 per cent during that period.

The task of the district nurses was challenging. The areas for which they were responsible were vast. At times, they could travel by train, but in most instances they had to rely on boats on the rivers, or on horses or dog sleds. Their responsibilities included the care of women in their homes during pregnancy, labor, the puerperium, and then of their babies. In the event of complications, there was frequently no other nurse or a doctor who could be consulted by telephone or messenger.

Some of these nurses had no other preparation in obstetrics than what they had received as student nurses. Some had certificates for the practice of midwifery that they had secured in Britain and were better prepared. A number of the former group realizing their need for more education and experience, went to Britain and studied midwifery for a year. Then they returned to continue their work.

During the years immediately following World War I, another migration of people into the province occurred. Some came from Europe in search of homes for their families, free from the threat of war. Others came from distant parts of this continent, encouraged by the building of railways to the north and the development of a species of wheat that matured early. To meet their needs, more nurses were sent out into the isolated areas where these people settled.

The conditions under which the district nurses worked continued to be difficult even into the 1930's.

> One nurse told the story of a patient, an 18-year-old primipara, who progressed satisfactorily through her first and second stages of labor but in the third stage partially retained the placenta with serious hemorrhaging. The nurse knew that the placenta had to be removed. She attempted to do this manually. However, since she did not know the correct technique, she felt it tearing in her hand and had to stop. The telephone service in the village closed at 6:00 P.M. but fortunately a doctor was contacted at 9:00 P.M. He was only 25 miles away as the crow flies, but 100 miles by road. The doctor agreed to come on the condition that a car could be sent for him. An Anglican minister offered to make the trip. The doctor arrived, removed the placenta, remarked that the patient "would bleed no more because she was so nearly bled out," and departed. Fortunately the patient recovered.

When World War II began many doctors enlisted. There were fewer of them, sometimes none, who could be consulted or called in by the district nurses. Because of wartime conditions, it was impossible for nurses to go to Britain to study. One nurse, who was practising at this time, remarked that in spite of her four-month postgraduate course in obstetrical nursing, and her six years' experience as an obstetrical supervisor, she still felt the lack of advanced knowledge. Something had to be done!

The Advanced Practical Obstetrics Course was started by the School of Nursing, University of Alberta. The aim was to prepare district nurses to handle maternity work in the remote parts of the province. The first stu-

Miss Madden is lecturer in obstetrical nursing at the School of Nursing, University of Alberta.

dents were district nurses or those who planned to work in the field. Two years later, nurses in charge of small hospitals were accepted, since it was necessary for them to assume responsibility in the absence of a doctor.

During the first two months detailed instruction was given in the classroom and local hospitals. Lecture content was concerned mainly with normal obstetrics but included abnormal conditions as preparation for the times when the nurse would be unable to secure the help of a doctor. The third and last month of study was spent in a district nursing centre. The course progressed well. The students were enthusiastic and used the knowledge and experience to good advantage in their work.

During the years since this beginning, changes have been made in the course of study. The present aim is to prepare nurses for leadership in maternal and child health, that is, for responsibility in any position in obstetrics, either in large or small hospitals or in the remote areas of the north. Although all phases of the subject are covered, special emphasis is given to the emotional care of the patient, patient teaching and prevention of complications. The course has been increased to 20-weeks and is divided into three sections:

Part I: (10 weeks) Includes lectures in anatomy and physiology; obstetrics; pediatrics; gynecology; genetics; breathing and relaxation; nursing care; how to study and public speaking; observation and experience in doctors' offices, in the obstetrical clinic of an out-patient department, and in the wards of local hospitals including one week in a premature nursery; practice teaching of patients and student nurses. A project, a long-term assignment, on a subject of the student's choice, is started during the fifth week. Three examinations are given during the last weeks.

Part II: (8 weeks) Spent in a selected hospital in the province, with experience on the ward, in the nursery and in the case room. The student assists in a minimum of 20 deliveries under the instruction, supervision, and responsibility of the patients' doctors.

Part III: (2 weeks) Conclusion of the course. Each student presents a report on her field experience and her project. There are a few lectures, some field trips, and the final examinations.

Since the fall of 1958, there has been a marked change in the type of work done by the nurses who enrol for the course. The majority are now preparing for work in hospitals, as is shown by a review of recent applicants: An obstetrical supervisor; a supervisor of a premature nursery; clinical instructors; head nurses; staff nurses in obstetrical departments; case room nurses from small hospitals. We have had two missionary nurses and an occasional public health nurse. Many students have come from distant parts of Canada. There have been nurses from Newfoundland, Prince Edward Island, New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan and British Columbia and two from the United States. This distribution may be accounted for by the fact that this is the only course in Canada that gives this more detailed theory and advanced responsibility, including the delivery of patients.

In the fall of 1960, the School of Nursing of the University of Alberta moved to its new department on the fifth floor of the Medical Sciences building. A classroom was reserved for the Advanced Practical Obstetrics Course. The students of the Spring 1961 course were the first to use it.

It is hoped that this course will be granted recognition by the Central Midwives Board of London, England, as the equivalent of a part of their Midwifery Course. Negotiations between the Board and the School have been in progress for some time. The Board plans to send a representative to visit the School in the near future.

Such is the Advanced Practical Obstetrics Course. It has changed and will continue to change to meet the needs of nurses who are preparing for leadership in maternal and child health.

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Book Reviews

Medicine for Nurses by M. Toohey, M.D., M.R.C.P., D.C.P. 667 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 5th ed., 1960. Price $5.00.

Reviewed by Miss Helen Ralph, Prince County Hospital, Summerside, P.E.I.

The objective of this text is stated in the preface: "I have tried to make it (the text) as comprehensive as possible so that it will not only help the nurse in her training, but also serve as a reference book afterward." Anyone who is familar with this book will agree that the author has achieved his aim. Recent developments, both in treatment and in the use of new drugs, have been incorporated. In addition the lists of preparations at the end of the book have been revised and enlarged. A new illustration has been included.

For those who are unfamiliar with the text, the author introduces medicine to nurses by dealing with the basic physiological facts that are needed for an understanding of the various diseases and their treatment. The major medical diseases are dealt with according to the body systems that they affect.

A special mention of the tables, graphs, colored photographs, and especially the original sketches is called for. They not only make the book attractive, but emphasize in a simple and effective fashion, the salient facts related to the most important diseases.

Another pleasing feature, which is excellently done, is the inclusion of a detailed summary, at the end of the most important chapters. The author has included the diagnostic tests and routine procedures related to the diseases discussed in the chapter.

An interesting chapter, contributed by Dr. H. R. Rollins, a British psychiatrist, on psychosomatic medicine, introduces some of the psychoneurotic disorders; the psychological development of the individual and the psychological effects of illness on him.

The book is excellent, especially for review purposes. It is written in a concise style, uncluttered by too much detail, yet adequate enough to give a clear understanding of the subject matter. The author has done a splendid job in correlating and integrating such studies as psychology, pharmacology, diet therapy and anatomy and physiology with medicine.

Despite the feelings of the author that nursing care is better learned in the clinical area, I feel that this text would be more valuable if this aspect had been included to some extent, especially since teaching is being directed to the patient-centred, rather than the disease-centred approach. I would also like to see review questions included at the end of each chapter.

I would recommend this text as a valuable reference book and suitable for a school of nursing library and a ward library. I might add that in our own library, we do have several copies and our students like it.

Foods Without Fads by E. W. McHenry, Ph.D. 159 pages. J. B. Lippincott Company, 4865 Western Avenue, Montreal. 1960. Price $4.00.

Reviewed by Miss Rosamond H. Ross, Nutrition Consultant, 4157 West 13th Ave., Vancouver.

It would seem that hunger is only one of the many factors influencing food selection in our affluent society. Often people select food according to fads and misleading information found in advertising, articles and books, rather than the results of scientific research. There has long been a need for an easy-to-read book to give the lay person a common sense guide to nutrition. Dr. McHenry has answered this need admirably. His text can be read easily in an evening or two. The print is large but I feel that a few pictures and illustrations would have livened the pages.

The results of nutrition research are difficult to express in simple language. For that reason this book can be an important aid to those teaching nutrition. It will probably be of general interest to many doctors and nurses. Some of them may discover that a few of their common beliefs about nutrition are really food fads.

The homespun philosophy and practical examples set it apart from a truly scientific book. The traditional approach to teaching nutrition through explanation of sources and functions of nutrients has been avoided by including such "come-hither" chapter headings as:

Sweet Foods, Nice to Eat But . . .
We Don't Need to be Fat
Food Nonsense is a Nuisance
Food or Pills

The meaning of food to people, the necessity of eating a variety of foods in moderation and the esthetic satisfaction and enjoyment that may be derived from the preparation and serving of meals are points of view emphasized throughout.

Pharmacology in Nursing by Elsie E. Krug, R.N., M.A. 805 pages. The C. V. Mosby Company, St. Louis, Mo. 8th ed., 1960. Price $6.00.
Reviewed by Miss Florence Fleming, Instructor in Nursing Sciences, Vancouver General Hospital, Vancouver.

The former edition of this book, written jointly by Krug and McGuigan proved to be very valuable. Like other pharmacology texts it became somewhat outdated by the many changes in ideas concerning drug therapy and the advent of newer drugs. It was timely, then, that one of the authors should revise it immediately following the 16th revision of the Pharmacopeia of the United States (1960) and the 11th edition of the National Formulary (1960).

The author has chosen to present this broad subject on the basis of body systems and the effects of drugs on them. Included in the general introduction are the scope of pharmacology; how to study pharmacology, and a chapter reviewing basic arithmetic. The metric system of measurement has been indicated throughout in keeping with the general trend toward the adoption of its use and the exclusion of the apothecary system. There is a new section, especially useful for us, on Canadian drug legislation and the position of the nurse in relation to the use and possession of narcotics.

Some of the older drugs have been deleted unless they are still employed for therapy. Newer, favored drugs have been included throughout but attention should be drawn to the chapters on antihistamines, drugs used for motion sickness, anti-neoplastic drugs, and enzymes. The latter have not been treated as entities before.

Emphasis has been placed on drugs as chemical substances. By the inclusion of structural formulae the reader is encouraged to understand the inter-relationship of the drugs and their action. Suggestions for review and study, including sample questions, are to be found at the end of many chapters. These should facilitate learning and application. The extent of the material may be considered needlessly detailed for the beginning student in pharmacology. However this text should be of great value to students at all levels as a text and reference book.

Emotional Maturity — the Development and Dynamus of Personality by Leon J. Saul, M.A., M.D. 393 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 2nd ed., 1960. Price $6.50.
Reviewed by Mrs. Beverly Du Gas, Associate Director, Nursing Education, Vancouver General Hospital, Vancouver 9.

The author has attempted to explain, in simple terminology, the basic motivational forces underlying human behavior. The book is intended for use by those concerned in working with people. This includes not only psychiatrists and physicians in other specialties who are interested in the scientific basis of medicine, but also those in fields such as law, religion, industry and social work.

Dr. Saul has carried as his central theme his belief that the mature individual is one who has successfully resolved the passive receptive dependent tendencies of childhood, and has become an independent person capable of giving love to others and of accepting responsibility for himself and his family. As a corollary, Dr. Saul explains his belief that neuroses and other forms of maladjustment

(including alcoholism) are caused by a carry-over into adulthood, of the childish tendencies of passivity, receptivity, and dependence.

The author has incorporated basic psychoanalytic concepts into his text in an understandable and enlightening way. He refers frequently to patients he has known to illustrate his principles. These case histories make the book interesting and very readable. The poems by Ogden Nash and others with which he supplements his discussions, are both amusing and pertinent.

The book stresses the importance of prevention in psychiatric illness as well as in other branches of medicine. Children need a proper emotional climate in which to develop and mature for "as the twig is bent, so grows the tree." Both student and graduate nurses will find this text a good reference for psychology and psychiatry.

IN THE GOOD OLD DAYS

(*The Canadian Nurse* — AUGUST 1921)

An Airplane that can rise straight into the air from the ground has been successfully tested. It is called a helicopter and is driven upward by whirling screws. It was invented by a lieutenant of the Australian Army Balloon Corps, and is officially acknowledged to be the first in the world, which, after making the ascent, remained hovering in the air. A British helicopter has been invented which not only rises straight in the air and hovers there, but can also move from point to point. These machines are said to solve the problem of vertical flight.

* * *

A series of porcelain coins for Guatemala has been designed at the porcelain works at Meissen, Saxony, long famous for its manufacturing of porcelain. If it is accepted, this currency will replace the money made of hard rubber now in circulation in the Central American Republic. Paper money cannot be used there because of the climate.

* * *

Cultured pearls — The Japanese have discovered a method of producing pearls at will. A foreign substance is introduced under the liver of the oyster, which is then returned to its bed in the sea. The irritation caused forces the oyster to cover the offensive irritant with an exudation called nacre, and in time it becomes a pearl. The size depends upon the length of time it is permitted to grow. Pearls can be grown as large as six or seven grains. This discovery has had a depressing effect on the pearl market.

* * *

A Scottish woman, a Mrs. Ross of Caithness, has recently died at the age of 101. She had never been ill until within four or five days of her death; had never consulted a doctor, nor tasted medicine.

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The Canadian Nurses' Association has not reviewed the personnel policies of the hospitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to:
THE CANADIAN NURSE JOURNAL
1522 SHERBROOKE STREET WEST
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ALBERTA

Registered Nurses & Certified Nursing Assistants (Immediately) for 65-bed hospital. Salary $295-$325; $185-$215 experience considered. Liberal policies, 40-hr. wk., train fare from any point in Canada refunded after 1-yr. employment. Apply: Sister Superior, Providence Hospital, High Prairie, Alberta.

General Duty Registered Nurses (immediately) salary $325 per mo., plus by-yearly increments. Paid holidays & sick leave, room & board $30 per mo., group medical & hospitalization plans. Apply: P.O. Box 339, Spirit River, Alberta.

General Duty Nurses — starting salary $290 per mo., 40-hr. work wk., board, room & laundry available, if desired, $30 per mo. Civil Service holiday, sick leave & pension programs. Apply to: Baker Memorial Sanatorium, Calgary, Alberta.

General Duty Nurse for 16-bed hospital, starting salary $285 per mo., 40-hr. wk., board & room $35, uniforms laundered free. Municipal Hospital, Elnora, Alberta.

General Duty Nurses Salary $285-$315 per mo. plus other benefits, 40-hr. wk. Train fare from any point in Canada will be refunded if employed for 1 year. For full particulars apply to: Municipal Hospital, Two Hills, Alberta, PHONE 335.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton, $285-$335 gross salary for Alberta registered, $275-$325 gross salary for non registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

Graduate Nurses for 50-bed hospital, on main line between Calgary & Edmonton. Salary scale $285 - $325 commensurate with experience, less $40 for full maintenance. 3 wks. vacation, plus 10 statutory holidays after 1-yr. of service. Vacancies occurring **September & October.** Apply to: Mrs. E. Harvie, Matron, Municipal Hospital, Lacombe, Alberta.

Public Health Nurse (after July 1st.) in the Peace River Country. Starting salary $3,630 with annual increment $120, 5-day wk., $100 initial uniform allowance, car provided, Reg. N. considered (if interested in public health nursing). Starting salary $3,300 with $120 annual increment. For personnel policies apply to: Dr. B. Heap, Medical Officer of Health, Health Unit, Peace River, Alberta.

BRITISH COLUMBIA

Nursing Supervisor B.C. Registered for new hospital at Golden, British Columbia, picturesque village in the beautiful Canadian Rockies, on C.P.R. & Trans-Canada Highway, 170-miles west of Calgary, Alberta. Please indicate qualifications & salary expected. Full information regarding duties & hospital operation & organization available on request. Apply to: C. F. Collins, Administrator, Golden & District General Hospital, P.O. Box 230, Golden, British Columbia.

Operating Room Supervisor with postgraduate training for modern active 154-bed hospital. Personnel policies in accordance with RNABC. Basic salary $342. Apply with full particulars to: Director of Nursing, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses for small active hospital. Salary $282 for unregistered Nurses in B.C. $297 registered with yearly increments. Nurses' home available. For further particulars write. The Administrator Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary range $297 to $359. Pre-planned shift rotation, B.C. registration essential 4-wk vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for new 82-bed hospital in the Aluminum City. Salary $312-$374, 40-hr. wk., 9 statutory holidays, 28 days vacation, 1½ days sick leave per mo., accumulative to 60 days. Residence available $45/month. Experience, "On Call" & postgraduate increments. 50% medical care plan paid. Superannuation. Apply: Director of Nursing, General Hospital, Kitimat, British Columbia.

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—non-registered $297, B.C. registered $312-$374. Travel allowance, newly furnished residence available. For full details contact: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $307, maintenance $47.50. 40-hr. 5-day wk., 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for modern 154-bed General Hospital. Basic salary $297, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270. Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. Very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty Nurses, Operating Room Nurse (1) (with postgraduate or equivalent) for July 1st. in very active 146-bed General Hospital. Required October 1, 1961 **Head Nurse** for women's Medical & Surgical 27-bed nursing unit. Personnel policies in accordance with RNABC. Rooms available in nurses' residence. Apply: Director of Nursing, General Hospital, Chilliwack, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $297-$359. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $285 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 year. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $297 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurse for 31-bed hospital, salary $302 per mo., **B.C. Registered Nurses** $312, with regular increments, 40-hr. wk., 4-wk. vacation, 1½ days sick leave per mo., Lodging $11 per mo. Fare from Vancouver refunded after 6-mo. For information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

Operating Room Nurse with postgraduate course for active operating room in General Hospital with School of Nursing. Salary $297 plus increment for experience. Must be eligible for B.C. Registration. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty positions available for Summer relief in all services, also several permanent positions. Basic salary $297 per mo., B.C. registration required, excellent personnel policies. For further details apply to: Director of Nursing, Royal Jubilee Hospital, Victoria, British Columbia.

MANITOBA

Matron (Immediately) for 35-bed hospital in Southern Manitoba. Starting salary $350 per mo. 40-hr. work wk., separate residence with room & board available at $45 per mo., free laundry services. Apply with references to: O. Hamm, Administrator, Altona Hospital District No. 24, Box 660, Altona, Manitoba.

Matron (1) duties to commence immediately. Salary $370 per mo. **Registered Nurse for General Duty** (immediately) salary $310 per mo. For both positions $5.00 increments every 6-mo. for 4-yrs. less $45 per mo. full maintenance, living quarters in hospital. Apply to: Medical Nursing Unit, Birch River, Manitoba.

Registered Nurses (2) or 1 Registered Nurse & 1 Licensed Practical Nurse for 18-bed hospital in western Manitoba. 40-hr. wk., starting salary R.N.'s — $305 per mo., L.P.N.'s — $215 per mo., board & room available $45 per mo. For further particulars & application forms please write: Miss Avis Haymen, Matron, Medical Nursing Unit, Rossburn, Manitoba.

Registered Nurses for 63-bed General Hospital. Salary range $295 to $335 with 40-hr. wk. Recreational facilities include curling, golfing & fishing. Apply to: Miss E. R. Shacklady, Director of Nurses, Swan River Valley Hospital, Swan River, Manitoba.

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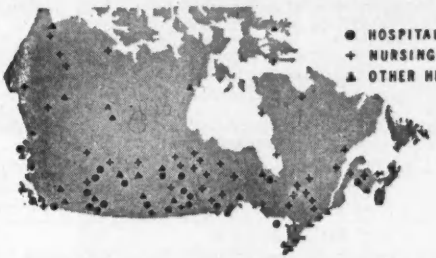

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For interesting, challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 705 Commercial Building, 169 Pioneer Avenue, Winnipeg 1, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Registered Nurses (2) Practical Nurses (2) for 29-bed hospital near Winnipeg. Salary $315 & $215 respectively. 40-hr. wk., vacation pay, 10 statutory holidays, paid sick leave, room & board $45, $10 increment yearly. **Registered Nurse** (1) with supervisory experience to assume duties of Director of Nursing by September 1961, commencing salary $360. Apply to: Administrator, De Salaberry Hospital District No. 27A, St. Pierre, Manitoba.

Registered & Licensed Practical Nurses. Salary rating for Registered Nurses min $285 - max. $319 per mo. with $10 additional for evening duty. For Licensed Practical Nurses min. $218 - max. $242 per mo., 8-hr. duty (day, evening or night), 40-hr. wk., living accommodation available. Apply in writing to the Personnel Office, Winnipeg Municipal Hospitals, Morley Avenue East, Winnipeg 13, Manitoba.

Operating Room Nurse for 63-bed General Hospital. Salary range $305-$345, depending on experience, 40-hr. wk., recreational facilities include curling, golfing & fishing. Apply to: Miss E. R. Shacklady, Director of Nurses, Swan River Valley Hospital, Swan River, Manitoba.

NEW BRUNSWICK

Matron for 14-bed hospital, general service, limited surgery, RNA salary scale, room, board & laundry $35 per mo. Experience in supervisory capacity essential. Travelling expenses paid from Maritime points. Grand Manan Hospital, North Head, New Brunswick.

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General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

ONTARIO

Director of Nursing for modern 75-bed hospital. Attractive growing town of 5,500. Starting salary dependent upon qualifications & experience. Please enclose references, give full particulars & date available in letter to the: Secretary, District General Hospital, Dryden, Ontario.

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Head Nurse for Newborn Nursery — previous supervisory experience — postgraduate study desirable — attractive personnel policies. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax, Ontario on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. Salary in accordance with qualifications & experience, increments every 6-mo., sick & vacation time after 6-mo., sick time cumulative to 14 days, 37½-hr. work wk., pension plan, living in accommodation. Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom,** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurses (September & November) for 19-bed General Hospital increasing to 25-beds this summer. Basic salary $300, room & board $30 in modern residence — single rooms. 6 monthly increments. For further particulars write: Miss J. Scollie, Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

Registered Nurses for 100-bed General Hospital, salary range $275-$375, increase $20 per mo., after 1-yr., 40-hr. wk., 3-wk. vacation, paid sick leave, O.H.S.C. pension plan, residence accommodation if required. Apply: Director of Nursing, Lady Minto Hospital, Cochrane, Ontario.

Registered Nurses $300 per mo. min. to max. $340, 3-weeks vacation with pay, sick leave after 6-mo. service. Non Registered — $15 less, Cert. N.A. $210 min. to max. $240, 2-wks. vacation with pay, Non Certified Cert. N.A. $200 to max. $230. Increases for both groups $10 per mo. after 1-yr. on staff. 9-statutory holidays. All staff:— 5-day 40-hr. wk. Apply: Superintendent, Englehart & District Hospital, Inc., Englehart, Ontario.

Registered Male Nurse for 95-bed General Hospital in attractive town on Lake Huron in a vacation resort area. Good personnel policies & 40-hr. wk., Residence accommodation available. Apply to: The Director of Nursing, Alexandra Marine & General Hospital, Goderich, Ontario.

Registered Nurses for 95-bed General Hospital in attractive town on Lake Huron in a vacation resort area. Good personnel policies & 40-hr. wk., Residence accommodation available. Apply to: The Director of Nursing, Alexandra Marine & General Hospital, Goderich, Ontario.

Registered Nurses for 60-bed hospital. Salary $280 per mo. gross. Good personnel policies. For further particulars apply: Superintendent, St. Marys Memorial Hospital, St. Marys, Ontario.

Registered Nurse for Rehabilitation Nursing. Night shift 1 week in nine. For appointment write: Matron, Lyndhurst Lodge Hospital, 153 Lyndhurst Avenue, **Toronto 4, Ontario,** or phone WA. 3-0928.

Registered or Graduate Nurses for modern 100-bed hospital, 40-hr. wk., rotating shifts, good location near Rideau Canal Summer Resort, 1-hr. from Ottawa, for further details apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario.

Registered Nurses, Certified Nursing Assistants for modern 75-bed hospital. Starting salary: R.N.'s $300 per mo. with merit increases after 6-mo. service, C.N.A.'s $216 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. & on the Trans-Canada Highway in the midst of large tourist area. For information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing, District General Hospital, Dryden, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $300 & $210 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospitals of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $305-$352. 28-day vacation after 1-yr. C.N.A. salary $221-$252, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience, $5.00 increment every 6-mo., 40-hr. wk., 8 statutory holidays. Room & board $45.00 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses & Certified Nursing Assistants (September 1st. or sooner) for 100-bed active General Hospital in Ottawa Valley. 45 additional beds opening late summer, 4-hrs. from Montreal, 2-hrs. from Ottawa, excellent train & bus service, 8-mi. from Camp Petawawa. Personnel policies include 5-day wk., 7 statutory holidays, 1¼-days sick leave cumulative to 60-days after 6-mo., 3-wks. vacation after 1-yr., employer participation in pension plan. Make application to: Miss E. Sheppard, Reg.N., Director of Nursing, Cottage Hospital, Pembroke, Ontario.

Registered Nurses for General Duty for 50-bed hospital, good salary & personnel policies. Apply: Director of Nursing, Memorial Hospital, Huntsville, Ontario.

Registered Nurses for General Duty in all departments including premature & new-born nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty in modern 18-bed Private Hospital, in iron mining town, 150-mi. north of Sault Ste. Marie, Ontario. Starting salary $281 min. to $316 max. for experience, less $20 per mo. for maintenance. Excellent accommodations & personnel policies, transportation allowance after 6-mo. service. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $285 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered Staff Nurses for Operating Room Department: A new well equipped unit; rotating hours of duty; attractive personnel policies. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

General Duty Nurses & Certified Nursing Assistants for modern 50-bed active hospital, 40-hr. wk. with all statutory holidays, pension plan & sick leave benefits. Meaford is situated on Georgian Bay & is an all year resort town. For further information apply to: Director of Nursing Services, General Hospital, Meaford, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $285 monthly, Graduates at $250; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $285, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $285 per mo. with recognition for P.G. courses, 40-hr. wk. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; $285 gross. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario.

General Duty Nurses for 350-bed General Hospital located in downtown Toronto — Rotating hours of duty, attractive personnel policies, in-service education program. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particulars, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

GENERAL STAFF NURSES for 100-bed General Hospital, salary, Registered Nurses $275 gross. Write: The Administrator, Norfolk General Hospital, Simcoe, Ontario.

Public Health Nurses required by Stormont, Dundas & Glengarry Health Unit for generalized program in Seaway Development Area, usual benefits, liberal car allowance, pension plan, allowance for experience. Apply to: Dr. Paul S. deGrosbois, Medical Officer of Health, Health Unit, 26 Pitt Street, Cornwall, Ontario.

Public Health Nurse (Qualified) for generalized program. Position available in Guelph suboffice. Good working conditions, new modern health centre, salary schedule with annual increments. Allowance for experience, 4-wk. vacation, generous car allowance. Apply to: Dr. B. T. Dale, Medical Officer of Health and Director, Wellington County Health Unit, Fergus, Ontario.

Public Health Nurse (qualified) salary $3,650 - $4,400, allowance for experience. 5-day wk., 4-wks. vacation, sick leave credits, P.S.I., pension plan. Apply to: Mr. A. F. Stewart, Secretary-Treasurer, Wentworth County Health Unit, Court House, Hamilton, Ontario.

Public Health Nurse will be required by the Kitchener Department of Health in September 1961. For further information write: Miss Olga Friesen, Department of Health, 233 Queen Street South, Kitchener, Ontario.

Public Health Nurses (2-qualified) for generalized program, annual increments $200, 5-day wk., car allowance 10 cents per mile, group insurance plan, 4-wk. vacation. Apply stating salary expected to: Dr. W. N. Turpel, M.O.H. & Director, Lennox & Addington County Health Unit, Napanee, Ontario.

Public Health Nurses (Qualified). Salary $3,500 - $4,575, annual increment $215. 5-day wk., transportation provided, the usual employee benefits. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, Oshawa, Ontario.

Matron for privately owned & operated hospital of 35-beds with Outpatient Department. Must be under 35 years of age & qualified to assume full responsibility. Special qualifications & postgraduate training necessary. Apply for particulars to: Dr. H. F. Mowat, Chief Surgeon, Copper Cliff, Ontario.

Public Health Nurses — Minimum salary $3,500, allowance for experience up to 3 yrs., car allowance, pension plan, & other benefits. Personnel policies on request. Apply to: Dr. J. M. McGarry, M.O.H., St. Catherines-Lincoln Health Unit, St. Catharines, Ontario.

Public Health Nurse, (qualified) for generalized program. Salary range $3,500 - $4,325 according to qualifications & experience. Car expense allowance & other benefits. Apply to: Dr. G. L. Anderson, Director, The Lambton Health Unit, Sarnia, Ontario.

Public Health Nurse (qualified) for Supervisory responsibilities, to serve as Assistant Supervisor. Salary range $4,400 - $4,940 according to qualifications & experience. Car expense allowance & other benefits. Apply to: Dr. G. L. Anderson, Director, The Lambton Health Unit, Sarnia, Ontario.

Public Health Nurses for generalized Public Health Nursing Service, Hospital P.S.I., pension plan, sick leave accumulative at the rate of 1½ days monthly, vacation 4-wk. per yr., car car allowance, salary ceiling at present $4,300, initial salary dependent on experience. Apply to: Dr. J. R. Mayers, M.O.H. and Director, Norfolk County Health Unit, Box 247, Simcoe, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

P.E.I.

Psychiatric Nursing Instructor for Mental Hospital conducting basic undergraduate 12-wk. course for affiliate students of nursing. Usual Civil Service benefits. For details apply: Director of Nursing Education, Hillsborough General Hospital, P.O. Box 4000, Charlottetown, Prince Edward Island.

Instructress for School for Nursing Assistants. Experienced in teaching basic nursing. Apply giving experience & reference in first letter to: Miss J. Dunning, Director, Central School for Nursing Assistants, P.O. Box 4000, Charlottetown, P.E.I.

BERMUDA

Registered Nurses. Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £46-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply: Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for 30-bed General Hospital, 50-mi. from centre of Montreal, excellent bus service. Starting salary $275 per mo., 3 semi-annual increases, 40-hr. wk., 4-wk. annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

Registered Nurses & Certified Nursing Assistants for modern 60-bed General Hospital, salary $275 per mo. 5 semi-annual increases; 40-hr. wk., 4-wk. vacation. Cert. N.A. starting salary $200, 3-wk. vacation. Accommodation available in new motel-style nurses residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Operating Room Nurses (4-immediately) to fill vacancies created by resignations & by the addition of a new theatre. Qualifications required, Registration in the Province of Quebec. Prefer postgraduate training in General & Neuro-surgery. Nurses with good experience but without P.G. acceptable. Submit applications to: Director of Nursing, Montreal Children's Hospital, 2300 Tupper Street, Montreal 25, Quebec.

Registered Nurses, Certified Nursing Assistants, for a new hospital which will be opened in September — 120 beds, 40 bassinettes. Attractive personnel policies and differential for afternoons, nights and special departments. Opportunities for promotion. Apply to: Director of Nursing, La Salle General Hospital, Ville La Salle, Quebec.

SASKATCHEWAN

Registered Nurses for Fort Qu'Appelle Sanatorium. Initial salary: **General Duty** $300 per mo. **Charge Nurses** $315 per mo., with semi-annual increments. Recognition for experience. 40 hr. wk., 4 wks. paid annual vacation, 10 statutory holidays, sick benefit & superannuation plans in effect. Room, board & laundry $37.50 per mo. Apply: Superintendent of Nurses, Fort San, Saskatchewan.

Registered Nurses for General Duty in Operating Room, Emergency & Ward service in 180-bed hospital. Working conditions as recommended by the Saskatchewan Registered Nurses' Association. Apply to: Miss G. I. Bradshaw, Director of Nursing, Victoria Union Hospital, Prince Albert, Saskatchewan.

General Duty Nurses for 8-bed hospital. Basic salary $290, personnel policies as SRNA. Apply to: Matron, Union Hospital, Rockglen, Saskatchewan.

Operating Room Nurse for 26-bed hospital in Northern Saskatchewan; starting salary $325, also **Registered Nurse** starting salary $300. 2½% semi-annual increments. Consideration given for qualifications & previous experience. Complete maintenance at $30. 1-mo. annual vacation, fare paid from Prince Albert or Edmonton. Apply: Matron, Municipal Hospital, Uranium City, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

ALBERTA ASSOCIATION OF REGISTERED NURSES

Invites Applications for

COMMITTEE CO-ORDINATOR

To be the third member of the professional staff of Provincial Office. Broad knowledge of nursing service, nursing education and advanced preparation desirable. Duties will include co-ordination of activities of A.A.R.N. Committees. Salary based on experience and preparation. Personnel policies include pension plan.

Apply To: THE EXECUTIVE SECRETARY

ALBERTA ASSOCIATION OF REGISTERED NURSES

10256 - 112TH STREET — EDMONTON, ALBERTA.

DIRECTOR OF NURSING

Director of Nursing wanted. Modern 750-bed accredited civic General Hospital (200-bed addition being built). Responsible position. To plan and direct education and service programs. Perquisites include suite with service, pension plan, four (4) weeks vacation, sick benefits. Salary $7,000 - $9,000 annually depending upon qualifications and experience. Duties to commence as soon as possible.

Address replies to:

CHAIRMAN, CALGARY HOSPITALS BOARD,
CALGARY GENERAL HOSPITAL, CALGARY, ALBERTA.

NURSES NEEDED IN NORTH

General Duty Registered Nurses for new modern 16-bed hospital, to start immediately. Starting salary $285 per month, increments to maximum of $315 less $35 for full maintenance. Will pay train or bus fare one way and one month vacation with pay after one year's service.

APPLY: **ADMINISTRATOR,**
MUNICIPAL HOSPITAL, MANNING, ALBERTA.

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

Registered Nurses, Therapists, X-ray Technicians & Laboratory Technicians. El Camino Hospital, 307-beds, opening September 1, 1961, now accepting applications. Location, Mountain View — Los Altos — Sunnyvale area, 35-mi. south of San Francisco & 10-mi. north of San Jose. There are 3 colleges within 15-min. of the hospital — Stanford University, Santa Clara University, & San Jose State College. Write: Director of Personnel, El Camino Hospital, 2500 Grant Road, Mountain View, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $350 with range to $390 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) **Staff Nurses for permanent positions,** various departments, days, eves, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $345 - $415, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Attention! General Duty Nurses 400-bed fully accredited County Hospital located 2 hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., pd. vacation, paid holidays, pd. sick leave, retirement plan, social security, & insurance plan. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $376 per mo. plus shift & service differentials. Must be eligible for California Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro, area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 200-bed General Hospital in the heart of Los Angeles cultural & educational center. General Duty $350 per mo., min. days; $35 differential for 3-11 & $30 differential for 11-7. Time and ½ over 40-hr. wk., social security, state disability insurance, 2-wks. vacation end of 1-yr., 3-wks. after 5-yrs., 7 paid holidays, 12-days sick leave. Cotton uniforms laundered, nurses' residence $10 per mo. Graduates of accredited schools, California license obtainable immediately. Promotions made from staff whenever possible. Apply: Mary Topper, R.N., Director of Nurses, Santa Fe Hospital, 610 South St. Louis Street, Los Angeles 23, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Duty Nurses for 72-bed hospital located in college town in mountainous portion of Colorado. Salary $350 per mo. with periodic increases, fringe benefits — including meals, sick leave, vacation, etc. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered Nurses for expanding 424-bed General Hospital near Chicago's West Side Medical Center. Starting salary $390; $420 for P.M.'s & nights. Benefits include 8 paid holidays, up to 4-wk. vacation, sick leave, Blue Cross & pension plan. Convenient to "Loop" & super highways. Private room accommodations available. Write: Diretor of Nursing Service, Dept. C.J.N., Mount Sinai Hospital Medical Center, 2750 W. 15th. Place, Chicago 8, Illinois.

Registered General Duty Nurses for 200-bed General Hospital. Located along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $380 for days, $410 for evenings, $400 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Operating Room Nurses (Days & P.M.) 200-bed General Hospital located along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $405 days, $435 evenings, $425 nights, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Staff Nurses present 260-bed hosp. with 120 Med-Surg. beds now under construction for completion Aug. 61. Trans. pd. 1st. class air to Albuq. & return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment". Career opportunities, largest pvt. JCAH accredited hosp. in state; near U of New Mexico — R.N. & B.S.pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds. & O.R. Salaries $315 per mo. Even., Night or O.R. with call; 6-mo. increases up to $375; Days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent. P.M. or night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp., Services, pd. sick leave cumulative to 5-wks., annual physical exam., vacation 1-yr-2-wks., 2-yrs.-3-wks., 5-yrs.-4-wks. Active inservice pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Centre, 1012 Gold. S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

COURSES FOR R.N.'S N.Y. POLYCLINIC MED. SCH. & HOSP. — in heart of Manhattan — 6 mos. courses in: O.R. NURSING, OPD. NURSING, MED.-SURG. NURSING. Classes 4 times yrly: Mar., June, Sept., Dec. Room, meals, Medical Care & monthly cash stipend. Positions available to graduates of our Courses. For information write: Director of Nursing Education, 345 W. 50 St., N.Y.C., NEW YORK.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $372. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

General Duty & Operating Room Nurses for 210-bed General Hospital. Start $335 days, $360 evenings, $355 nights, plus $10 for O.R., university city, 40-hr. wk., 7 holidays, extended vacations, sick leave benefits, free Blue Cross hospital-medical insurance & $2,500 life insurance, retirement program plus Social Security, extensive Intern-Resident Educational Program, living quarters available. Write, Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington.

Registered Nurse, unencumbered, preferably 35 or over, permanent **Supervisory** position for 44-bed Geriatric Sanatorium, West Los Angeles, Calif., Calif. licence required. Top salary depending on qualifications, housing available. Write: Mr. I. Zide, Adm., 3480 Sawtelle Blvd., Los Angeles 66, California.

BRITISH COLUMBIA

Graduate Nurses: Permanent & holiday relief nurses for active 50-bed hospital 35-mi. from Vancouver. RNA of B.C. recommendations implemented. Apply to: Director of Nursing, Langley Memorial Hospital, Murrayville, British Columbia.

ONTARIO

Assistant Head Nurse (immediately) for 50-bed Surgical Unit in modern 162-bed hospital. Starting salary commensurate with qualifications & experience. Hospitals of Ontario pension plan, excellent personnel policies. Stratford is a delightful city of 20,000, within easy reach of larger centres. Applications, stating qualifications & experience to: Director of Nursing, General Hospital, Stratford, Ontario.

SASKATCHEWAN

Director of Nursing for modern 26-bed hospital in Northern Saskatchewan, serving a community of 3000. Starting salary $400. Complete maintenance with private suite at $30, one month annual vacation, air transportation paid to & from Prince Albert or Edmonton once a year. Apply giving full particulars of training & experience to: Administrator, Municipal Hospital, Uranium City, Saskatchewan.

NEW 118-BED ADDITION
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Will afford job opportunities
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Beautifully located on
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Modern Nurses' Residence

Apply to:
THE HOSPITAL ADMINISTRATOR,
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requires

combined occupational therapist and physiotherapist for 155 bed hospital in St. Anthony, Newfoundland.

For particulars write:

Miss Dorothy A. Plant, Secretary
GRENFELL LABRADOR MEDICAL MISSION,
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OTTAWA

DIRECTOR OF NURSING

For modern General Hospital, expanding to 50-beds, 12 bassinets, completion in 1961. Residence accommodation available.

Salary commensurate with experience and qualifications.

Apply giving full particulars of training and experience to:

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PORCUPINE GENERAL HOSPITAL,
SOUTH PORCUPINE, ONTARIO.

REGISTERED NURSES

SALARY RANGE $306 - $332
Required by

The Municipality of Metropolitan Toronto for Greenacres Home for Aged in Newmarket, Ontario.

Permanent position, 40-hour week, good employee benefits.

Apply:
PERSONNEL OFFICE,
387 BLOOR ST. E., TORONTO 5, ONTARIO

PUBLIC HEALTH NURSE (Qualified)

for generalized program, Town of New Toronto, salary range $3,500 to $3,800 starting salary depending upon experience, 5 day week, pension benefits, sick leave plan, Ontario Hospital Services, P.S.I., car allowance provided. *Apply to:*

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to organize and supervise nursing service in new mental health division.

Unique opportunity to participate in interesting pilot project in psychiatric care.

For further information apply to:

DIRECTOR OF NURSING, ROYAL OTTAWA SANATORIUM,

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ALBERTA

DIRECTOR OF NURSING Royal Alexandra Hospital, Edmonton, Alberta, for 729-bed General Hospital now expanding by the addition of 600 more beds. Contains new nurses' residence & training school which is one of the finest in Canada. Masters Degree preferred but not essential. State qualifications & salary expected. Please furnish references. Apply: B. C. Whittaker, Q.C., Chairman, Edmonton Hospital Board, Room 304 Canadian Bank of Commerce Building, Edmonton, Alberta.

BRITISH COLUMBIA

Registered Nurse with O.R. experience for 26-bed General Hospital, 100-mi. from Vancouver in the Fraser Valley. RNABC policies in effect. Residence accommodation available. Duties to commence **September 1st.** Apply: Director of Nursing, Fraser Canyon Hospital, **Hope,** British Columbia.

MANITOBA

Registered Nurse (1) required by October, for 18-bed hospital, starting salary $315 less $45 maintenance, $10 annual increment for 4 years. Liberal personnel policies. Apply to: E. Green, Matron, Crystal City Memorial Hospital, Crystal City, Manitoba.

ONTARIO

Registered Nurses Applications & enquiries are invited for General Duty positions on the staff of Manitouwadge General Hospital. Modern, well-equipped 33-bed hospital in new mining town, about 250-mi. East of Port Arthur & North-West of White River, Ontario. Excellent salary & fringe benefits, liberal policies regarding accommodation & vacation. Population 2,500. Nurses' residence comprises individual self-contained apartments. Apply, stating qualifications, experience, age, marital status, phone No. etc., to: The Administrator, General Hospital, Manitouwadge, Ontario. Phone TAylor 6-3251.

Public Health Nurse for City of London, Must have Public Health nursing degree. Full civic benefits. Salary dependent on experience & qualifications with range from $3,530 yearly. Address all correspondence to: W. J. Anthony, Personnel Director, City Hall, London, Ontario.

Husband & Wife: available this fall; Can. Reg. Nurse with special experience in Pediatrics & Obstetrics. Husband, senior X-ray technician with exp. in every form of radiological examination. Write to: Mr. C. Norman, 211 Patricia Avenue, Ottawa, Ontario.

SASKATCHEWAN

OBSTETRICAL SUPERVISOR for 25-bed Obstetrical Unit. Qualified to teach student nurses. For further information apply to: Director of Nursing, Moose Jaw Union Hospital, Moose Jaw, Saskatchewan.

U.S.A.

Registered Nurses — most departments, including Surgery, for 165-bed fully accredited hospital. Excellent salary & benefits. Apply: Personnel Director, St. Luke Hospital, 2632 E. Washington Street, Pasadena, California. Home of the Rose Parade.

Registered Nurses Excellent opportunities due to expansion of our 525-bed General Hospital, located in the Capitol of California. Area noted for its recreational activities. Starting salaries: General Duty $370 per mo., Operating Room $395 per mo., $25 P.M. & night differential, liberal employment benefits. Write: Personnel Office, Sutter Community Hospitals, 2820 — L Street, Sacramento, California.

GRADUATE NURSES

Wonderful opportunity to advance in Senior position — some of these in New Medical/Surgical Unit. 40 hour 5 day week. Accommodation available in Nurses' Residence. New Progressive hospital in Montreal's West End.

Apply to:

PERSONNEL DEPARTMENT, VERDUN PROTESTANT HOSPITAL, 6875 LA SALLE BLVD., VERDUN, QUEBEC.

FIELD SECRETARY

Public Health Nurse required by a voluntary health organization for a new position involving field work in Ontario.

For complete information regarding the position and the personnel policies, enquiries may be addressed to:

THE EXECUTIVE DIRECTOR,
ONTARIO DIVISION, CANADIAN CANCER SOCIETY,
165 BEDFORD ROAD, TORONTO 5, ONTARIO.

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $285-$335 per mo. Certified Nursing Assistants $210-$240 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

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REGISTERED NURSES
NURSING ASSISTANTS

Required for all departments in new 160-bed hospital, centrally located between Toronto and Hamilton, in a very progressive community.

Good salary and personnel policies, pension plan, 40-hour week.

Apply stating age, qualifications to:

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OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL, OAKVILLE, ONTARIO.

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $285-$315 monthly ($131.20 - $145 bi-weekly) $265 monthly ($122 bi-weekly) until registered. Rotating periods of duty — 40 hour week, 8 statutory holidays, annual vacation 21 days. Annual sick time 12 days, cumulative to 18 days. Hospitals of Ontario pension plan, Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

NURSING SECRETARY

needed by

THE REGISTERED NURSES' ASSOCIATION OF NOVA SCOTIA

Our expanding program in nursing education and nursing service needs a well-qualified nurse to coordinate these activities with the school of nursing advisory program.

Qualifications: At least a bachelor's degree with preparation in nursing education and approximately ten years' experience in nursing education and nursing service.

For job specifications and personnel policies, apply to:

NANCY H. WATSON
EXECUTIVE SECRETARY, RNANS
73 COLLEGE STREET,
HALIFAX, NOVA SCOTIA.

THE ROYAL ALEXANDRA HOSPITAL

EDMONTON, ALBERTA

Requires

General Duty Nurses for Medical Surgical, Obstetrical and Pediatric Services and for the Operating Room.

Minimum salary $285 per mo. with Alberta Registration.

Good personnel policies.

Apply to:

DIRECTOR OF NURSING,
ROYAL ALEXANDRA HOSPITAL,
EDMONTON, ALBERTA.

HOTEL DIEU HOSPITAL

CORNWALL, ONTARIO

MODERN 300-BED HOSPITAL

requires

Clinical Instructor

in

MEDICINE, PEDIATRICS

and

OPERATING ROOM

also

General Staff Nurses

40 hour week — good salaries and personnel policies

APPLY:

DIRECTOR OF NURSING
HOTEL DIEU HOSPITAL
CORNWALL, ONTARIO.

CORNER BROOK

GRADUATE NURSES

are invited to enquire re:—

Employment opportunities in Canada's newest Province. Modern 110 bed hospital, progressive Community of 27,000, magnificent scenery and recreational facilities, transportation advanced, residence available.

Enquire to:—

DIRECTOR OF NURSING,
WESTERN MEMORIAL HOSPITAL,
CORNER BROOK,
NEWFOUNDLAND.

REGISTERED NURSES AS FLOOR SUPERVISORS

In Geriatric Institution near New York City. Starting salary $4,300 per annum, 37½-hour week plus fringe benefits totalling $700, includes 4 weeks paid vacation, 12 days paid sick leave, 7 paid holidays, Xmas bonus of 1 week's salary. No deduction for meals, residential accommodations $200 year.

Write:

EXECUTIVE DIRECTOR,
DAUGHTERS OF MIRIAM,
CLIFTON, NEW JERSEY.

Superintendent Administrator
ROSEWAY HOSPITAL
Shelburne, N.S.

Applications are invited for the position of Superintendent - Administrator of this 40 bed General Hospital operated by the Province of Nova Scotia.

For further particulars contact DR. D. S. ROSS, MEDICAL SUPERINTENDENT, ROSEWAY HOSPITAL, SHELBURNE, NOVA SCOTIA.

Application Forms may be obtained from the NOVA SCOTIA CIVIL SERVICE COMMISSION, P.O. BOX 943, PROVINCIAL ADMINISTRATION BUILDING, HALIFAX, NOVA SCOTIA.

OTTAWA CIVIC HOSPITAL

requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL
SURGICAL
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& PSYCHIATRIC } DEPARTMENTS

Apply

EDITH G. YOUNG, REG. N.,
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ST. JOSEPH'S HOSPITAL, HAMILTON

OFFERS

OPPORTUNITIES FOR REGISTERED NURSES

Positions available in all areas

560-bed hospital — 400-bed expansion program in progress.

Sound personnel policies
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DIRECTOR OF NURSING
2 ST. JOSEPH'S DRIVE, HAMILTON, ONTARIO.

THE GENERAL HOSPITAL OF PORT ARTHUR

Invites applications from

Registered Nurses for General Staff positions.

Excellent personnel policies.

For further information write:

THE DIRECTOR OF NURSING
THE GENERAL HOSPITAL OF PORT ARTHUR
PORT ARTHUR, ONTARIO.

WELLAND COUNTY GENERAL HOSPITAL

WELLAND, ONTARIO.

Located in the Niagara Peninsula requires

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

for both an active General Hospital, and a separate chronic and convalescent unit.

Apply to:

DIRECTOR OF NURSING

CLINICAL INSTRUCTORS IN PSYCHIATRIC NURSING

Department of Nursing Education
B.C. Mental Health Services

RESPONSIBILITIES — classroom and clinical teaching in Psychiatric Nursing to psychiatric and affiliate nursing students. QUALIFICATIONS — eligibility for B.C. Registration; university degree or certificate; graduate experience in nursing desirable. PERSONNEL POLICIES — 40-hour week Monday through Friday; four weeks' annual vacation, plus ten statutory holidays, medical and superannuation plans; SALARY commensurate with experience and preparation. For information and application forms write to The Associate Director of Nursing Education, Education Centre, ESSONDALE, B.C. COMPETITION NO. 61:178

REGISTERED NURSES
and
CERTIFIED NURSING ASSISTANTS
required by
TORONTO EAST GENERAL HOSPITAL

Residential Area. Good salaries and personnel policies 40-hour week — differential for evening and night duty. Pension Plan — Cash allowance for unused lil time.

Apply to: Director of Nursing,

TORONTO EAST GENERAL HOSPITAL,
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TORONTO 6, ONTARIO.

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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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